New Patient Questionnaire - Welcome to the Richmond Health Centre

To get to know you and assist care for your health needs, would you please complete the following information

Full Name: ..... Preferred Name: .....

DOB: ..... Age: ..... Ethnicity: .....

Address: .....

Cell Phone: ..... Work ph: ..... Home ph: .....

Occupation: ..... Preferred Pharmacy: .....

Date: .....

Please tell us about yourself, whanau/family, occupation, where you were born, where you have moved from, culture:

.....

.....

<u>Do you have any known ALLERGIES</u>? YES / NO

What medications? What happens? .....

Food Allergies? .....

Significant <u>MEDICAL HISTORY</u> and <u>FAMILY HISTORY</u> we should be aware of:

Have YOU had any of the following?	Yes	No	Family History:	Yes	No	Who	Age diagnosed
Heart attack			Heart attack				
Angina			Angina				
Stroke/ CVA/ TIA			Stroke/ CVA				
Diabetes			Diabetes				
High Blood Pressure			High blood pressure				
Cancer *Please provide detail below*			Cancer *Please provide detail below*				

Known medical conditions & surgical procedures	Medications:
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Do you take any 'over the counter' medications or dietary supplements? .....

Name: DOB:

Diet: .....

Exercise: What do you do?..... Do you consider it: Light / moderate / strenuous

Alcohol: *Please circle* Alcohol-free / Social / 5 or less nights per week / More than 5 nights per week

- How much would you have per week? Glasses of wine: ..... Beer-cans/ stubbies: ..... Spirit measures: .....

Do you smoke/vape? *Please tick as appropriate*

- Never smoked
- Stopped smoking. Quit date:……
- Currently smoking. I smoke ……. (how many) per day. I have smoked for ……..…. (how long)
- Currently vaping.

*"**Becoming smoke free is the best decision, for your health, a role model for their whanau/ family, & to save money**"*
May we refer you to a coach to help you become smoke-free? ***Yes/ No / In a month***

Breast Health: ***Please see your GP promptly if you have a current breast concern***

- Date of last Mammogram: .....

Breast Screening programme (BSP) *Funded for women aged 45 – 69y

- Are you enrolled? **Yes/ No** If you are eligible & not enrolled, do you consent to enrolment? **Yes/ No**

At Risk (annual) Breast Screening:

- **Do <u>you</u> have a history of breast cancer? Yes/ No.** Do you have any **family history** of breast cancer? **Yes/ No**

  If yes, what relationship they are to you, and what age were they when were they diagnosed? .....

Cervical smear history:

- Date of last smear: .....When is your next smear due?……

  - Have you had an abnormal smear requiring treatment? **Yes/ No**
  - Have you had a hysterectomy? **Yes/ No** If yes, was it for cancerous cells? **Yes/ No** Date: ……..
  - Have you been told you no longer need to have smears? **Yes/ No**

IUCD: Do you have an IUCD? **YES/ NO** Date of insertion: ..... Date due for replacement: .....

Depo Provera: Are you currently on Depo-Provera? **YES/ NO** Date last given: .....

Vaccine Information:

**Please provide records as evidence if vaccines were given overseas*

Tetanus Date given: ……

Measles Mumps Rubella *******If you were born after 1.1.1969* Dose 1: …… Dose 2: ……

Covid (Tick) Dose 1:……. Dose 2: …… Dose 3:…… Last booster date if known: ……

Other significant vaccines: ……..

**** If you have children joining our medical centre, please provide a <u>copy of your child's immunisations.</u>***

Once we have received your medical notes from your previous practice, we will be in contact with you to make a 'new patient appointment' with a Nurse. This will complete your enrolment. Thank you. We look forward to meeting you, Richmond Health Centre Team

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