auckland family medical centre
Auckland Family Medical Centre
94 Remuera Road
Remuera

Auckland Family Medical Centre
New Patient Medical Questionnaire

Please complete one form for each member of your family and hand back to reception

Name:_____ DOB: / /

1. Do you have any, or have had any of the following medical problems? or is there a family history of the following:

	Self	Family		Self	Family
Diabetes	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart attack <60yr >60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

2. Do you have any other health, disability problems or inherited conditions? – *please list*

3. Please list any regular medications that you take

4. Have had any operations? ☐ Yes ☐ No *If yes, please list*

5. Are you allergic to any medications? ☐ Yes ☐ No *If yes, please list*

6. Do you smoke? ☐ No ☐ Yes If yes, how many/day _____
   If Yes – would you like help to quit smoking ☐ Yes ☐ No
   Have you ever smoked ☐ No ☐ Yes If yes, how much and for how long _____
   when did you give up _____

7. Do you drink alcohol? ☐ No ☐ Yes If yes, how much/week _____
   and what type _____

8. Do you have any substance abuse problems? ☐ Yes ☐ No

9. Women: (*those over 20 years & sexually active*)
   When was your most recent cervical smear? _____
   Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know

   Have you had a mammogram (*those over 40 years*)? ☐ No ☐ Yes If Yes, when? _____

10. When was your last Tetanus booster?

11. Are your childhood immunisations up to date? ☐ Yes,if so where ? _____ ☐ No ☐ Don't know

IMMUNISATION RECORD: Please provide a copy of your immunisation record.

Signed:_____ Date:_____

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this. Please be careful to disclose all important medical/surgical/psychiatric information.

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Auckland Family Medical Centre - Patient Portal Registration Form

Please complete this form and supply one form of photo ID to register for the Auckland Family Medical Centre patient portal.

Each person that uses the portal must have their own unique email address.

Full Name: _____

Date of Birth: _____

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

<u>Practice use only</u>

Patient NHI: _____

Photo ID: _____

Staff Member: _____

Date: _____