

Te Ngae Medical Centre – Patient and family medical record



There are two pages to this questionnaire and we thank you for completing this form when you enrol and prior to your first consultation. We will keep the information on file to help provide you with the best quality care. The information will be kept with your confidential health records.

Name:		Date:	
Date of birth:	If English is not your first language, do you require an interpreter	If yes, which language?	
Gender (please circle) M F	<input type="checkbox"/> yes <input type="checkbox"/> No		
Occupation:			

Please list your current medications:

Current Medications: <i>please bring your current medications including inhalers with you to your first appointment.</i>		
Do you have any allergies and/or reactions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you have answered Yes, please specify name and type of reaction if you know it:		
Other important alerts, please indicate		
No Transfusions <input type="checkbox"/>	Needle phobia <input type="checkbox"/>	Sight impairment <input type="checkbox"/>
Hearing difficulties <input type="checkbox"/>	Mobility difficulties <input type="checkbox"/>	Special needs <input type="checkbox"/>
Other <input type="checkbox"/> <i>Please identify:</i>		Do you have a Power of Attorney? <i>If yes, please name:</i>
For women <input type="checkbox"/> When did you last have a cervical smear? Approx date:	<input type="checkbox"/> When did you last have a mammogram? Approx date: <input type="checkbox"/> Breast Screen Aotearoa <input type="checkbox"/> Private Where?	

Your Personal History

Do you now or have you had in the past any of the following?

(please tick appropriate box)

<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Irregular heart beat i.e., atrial fibrillation
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Angina	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Diabetes Type:	<input type="checkbox"/> Depression or related illness	<input type="checkbox"/> Cancer Type:
<input type="checkbox"/> Other hospital Admissions	<input type="checkbox"/> Other medical or family conditions	<input type="checkbox"/> Operations or injuries

Your Family Medical History –

Do any or your first degree relatives i.e., mother, brother, child – ever suffered from?

(please tick appropriate box)

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart attack <i>Who and at what age?</i>
<input type="checkbox"/> Stroke <i>Who and at what age?</i>	<input type="checkbox"/> Cancer <i>Who and at what age:</i> <i>Type:</i>
<input type="checkbox"/> Angina <i>Who and at what age?</i>	<input type="checkbox"/> Diabetes <i>Who and at what age?</i> <i>Type:</i>
<input type="checkbox"/> Other family medical conditions <i>Please list</i>	