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: **Gender** *(please circle)* **M F**	**If English is not your first language, do you require an interpreter** ☐ **yes** ☐ **No**	**If yes, which language?**
Occupation:		

Please list your current medications:

Current Medications: *please bring your current medications including inhalers with you to your first appointment.*		
Do you have any allergies and/or reactions?	☐ **Yes**	☐ **No**
If you have answered Yes, *please specify name and type of reaction if you know it:*		
Other important alerts, please indicate		
No Transfusions ☐	**Needle phobia** ☐	**Sight impairment** ☐
Hearing difficulties ☐	**Mobility difficulties** ☐	**Special needs** ☐
Other ☐ *Please identify:*		**Do you have a Power of Attorney?** *If yes, please name:*
For women ☐ **When did you last have a cervical smear?** **Approx date:……**	☐ **When did you last have a mammogram?** **Approx date……..** ☐ **Breast Screen Aotearoa** ☐ **Private** **Where?……**	If you aged between 45 and 69 years of age, and have not yet enrolled in BreastScreen Aotearoa, would you like the practice to enrol on your behalf? ☐**Yes** ☐ **No**
Are you a current Smoker? ☐ **Yes** ☐ **No** **If you have answered yes, would like us to contact you with Quitsmoking advice?** ☐**Yes** ☐ **No**		

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Your Personal History

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

(please tick appropriate box)

☐ **Asthma**	☐ **High Blood pressure**	☐ **Irregular heart beat i.e., atrial fibrillation**
☐ **Acid Reflux**	☐ **Heart Attack**	☐ **Stomach Ulcer**
☐ **Chronic Lung Disease**	☐ **Angina**	☐ **Hepatitis B**
☐ **Emphysema**	☐ **Stroke**	☐ **Hepatitis C**
☐ **Diabetes** **Type:**	☐ **Depression or related illness**	☐ **Cancer** **Type:**
☐ **Other hospital Admissions**	☐ **Other medical or family conditions**	☐ **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)

☐ **High blood pressure**	☐ **Heart attack** *Who and at what age?*
☐ **Stroke** *Who and at what age?*	☐ **Cancer** *Who and at what age:* *Type:*
☐ **Angina** *Who and at what age?*	☐ **Diabetes** *Who and at what age?* *Type:*
☐ **Other family medical conditions** *Please list*	