Introductory Health Questionnaire

Please complete form and hand directly to the doctor.

Full Name:_____ **Date of Birth: / /**_____

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	☐ Yes ☐ Yes	A migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Another lung, 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**? Or any other family history of health problems or inherited conditions? – *please list*

3. Please list any **regular medications/vitamins/supplements** that you take (include dose and frequency):

4. Have you ever been admitted to **hospital** or had any **operations?** ☐ Yes ☐ No *If **yes**, please list*

5. Please list any medications you are **allergic** to:

6. Do you **smoke?** ☐ Never ☐ Current - how many cigarettes/ day _____
Would you like help to **quit smoking** ☐ Yes ☐ No
☐ Ex-smoker – quit date _____

7. Do you drink **alcohol?** ☐ No ☐ Yes
How may UNITS do you drink per day? ☐ <1 unit/day ☐ 1-2 units/day ☐ 3-6 units/day ☐ 7-9 units/day ☐ >9 units/day

8. Do you use any **other substances**? ☐ Yes ☐ No

9. When was your last **Tetanus booster**? _____

10. Are your **childhood immunisations** up to date? ☐ Yes ☐ No ☐ Don't know

11. Have you had any covid-19 vaccines? ☐ Yes ☐ No ☐ Given Overseas

12. **<u>Women:</u>** (*those over 25 years & sexually active)*
When was your most recent **cervical smear**? _____
Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know
Can we get a copy of your smear record? ☐ Yes ☐ No
Have you had a **mammogram** (*those over 40 years*)? ☐ Yes ☐ No If Yes, when?_____

Signed:_____ Date:_____