**The Doctors Huapai New Patient Medical Questionnaire**

***Please be careful to disclose all important medical/surgical/psychiatric information.***

**Name Date of Birth:**

**Phone Email**

**1. Do you have any of the following?**

|  |  |  |
| --- | --- | --- |
| **Condition** | **Yes**  | **Specify** |
| Diabetes |  |  |
| High Blood Pressure  |  |  |
| Heart Disease |  |  |
| Heart Attack<60years >60years  |  |  |
| Angina |  |  |
| Asthma  |  |  |
| Other Lung or Respiratory Disease or problem  |  |  |
| Kidney Disease or Problem |  |  |
| Liver Disease |  |  |
| Hepatitis |  |  |
| Bowel Problems or Disease |  |  |
| Joint Disease or Problem |  |  |
| Arthritis |  |  |
| Depression and /or Anxiety |  |  |
| Other Mental Health Illness |  |  |
| DVT/ Blood Clot  |  |  |
| Stroke / CVA  |  |  |
| High Cholesterol |  |  |
| Migraine |  |  |
| Epilepsy |  |  |
| Breast Cancer |  |  |
| Other Cancer  |  |  |
| Glaucoma |  |  |
| Rheumatic Fever  |  |  |
| Tuberculosis (TB) |  |  |
| Eczema  |  |  |
| Hay Fever  |  |  |
| Other |  |  |

**2.Are you aware of anyone in your family e.g. siblings, parents, grandparents with any of the above conditions? If so, please list the conditions and family member below**

…………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….

**3. Current Medications** (including oral contraceptives and supplements)

…………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………. PTO

**4. Are you allergic to any medications or other substances?** – please list below and what reaction it is.

…………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….

**5.Please list any operations or procedures** (including approx. dates)

…………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….

**6. Any significant illnesses/ hospital admissions** (excluding operations)

…………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………….

**7. Smoking**

If yes, number per day? …… Have you considered giving up smoking Yes/ No

Do you want help and support to give up smoking? Yes /No

If NO have you ever smoked in the past, and if so how many per day, number of years smoking, and when did you stop? ……………………………………………………………

**8. Alcohol**

If you drink alcohol, how often and what do you drink in a typical session…………………………

Do you have a substance abuse problem? Yes/No ……………………………………………………………….

**9.Vaccination**

Do you know when you had your most recent tetanus booster?..................................

Are your childhood immunisations up to date Yes/ No / Decline

Would you like an annual flu vaccine? Yes / No

**10. For woman only** – please answer the following:

Do you have regular periods? Yes / No Contraception? (if relevant) ……………………

When was your last smear? …………. Last mammogram ……………. Normal Yes / No

 Normal Yes / No

Number of pregnancies? ………… Number of live births? ……………

Any complications of pregnancy? ……………………………………………………

**11. Do you have any disabilities eg visual impairment, hearing impaired, other?**

…………………………………………………………………………………………………………………………………………….

**12. Do you have a Living Will or Advance Directive?** Yes / No

**13. Is there anything else you think we should be aware of?**

…………………………………………………………………………………………………………………………………………….

**Thank You**