## Patient health questionnaire

Today's date :

**The relationship between a health care provider and patient is built on trust, honesty and sharing of information. I kindly ask that you complete this questionnaire as completely as possible as this will help us to identify and serve your medical needs in the best possible way.**

**Patient name:** **DOB:**

**Gender:**

If the person completing this form is not the patient, please write your name, your relationship to the patient and why the patient is unable to complete the form.

| | | | |
|---|---|---|---|
| Name: | | Relationship to patient: | |
| Reason: | | | |

| Patient Address: | Phone | |
|---|---|---|
| | Home: | |
| | Work: | |
| | Cell: | |
| | E-mail: | |

**Emergency contact:**

| Name and address: | Phone: | |
|---|---|---|
| | Home: | |
| | Work: | |
| | Cell: | |
| | E-mail: | |

Ethnicity:

I understand English well Yes

If NO, please specify the language you prefer:

*You are welcome to have an interpreter with you during consultations.*

Do you have any religious or cultural beliefs that may impact your health care? Yes

If YES, please describe:

I best learn new information by:

I prefer receiving correspondence, test results and reminder letters from you by:

The information on this page was reviewed with the patient

Name and Phone Numbers for Health Care Providers from whom you are currently receiving care (or have seen in the past 12 months), or from whom you have received prescriptions.

| Name | Specialty (e.g. GP, Surgeon, Acupuncturist) | Clinic name | Telephone no. |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |
| | | | |

Please list all of the medications you are currently taking. Please include over the counter medications, herbs and vitamins.

| Medication name | Dose | Last taken | Medication name | Dose | Last taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |

Please list and describe allergic reactions you have had to food, medications or insect stings.

| List food, Medication or Insect allergy | Describe your reaction |
|---|---|
| | |
| | |
| | |
| | |

Please list your present and past occupations.

| Occupation | Start date | Stop date | Responsibilities |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |

Have you ever been exposed to known cancer causing agents or inhalation hazards? *(e.g. asbestos, paints, aniline dyes, chemicals, etc.)* Yes

. If YES, please provide details

| Agent | Exposure time | Problems related to exposure |
|---|---|---|
| | | |
| | | |
| | | |

Please describe your hobbies.

Have you travelled in the past year? Yes if YES, please provide details.

| Travel destinations OUTSIDE NZ | Dates spent at this destination |
|---|---|
| | |
| | |
| | |

| Travel destinations INSIDE NZ | Dates spent at this destination |
|---|---|
| | |
| | |
| | |

Do you exercise? Yes

If YES, describe how long and how often you exercise on average each week.

In the past 12 months, have you fallen? Yes

If YES, please complete the following details

| | |
|---|---|
| Number of times you have fallen | |
| Injuries sustained due to the fall | |

Have you ever had any of the following vaccinations?

| Vaccine | | Date of last vaccination | Vaccine | | Date of last vaccination |
|---|---|---|---|---|---|
| Influenza | ◯ Yes ◯ No | | Hepatitis B | ◯ Yes ◯ No | |
| Tetanus | ◯ Yes ◯ No | | Typhoid fever | ◯ Yes ◯ No | |
| Pneumonia | ◯ Yes ◯ No | | Yellow fever | ◯ Yes ◯ No | |
| BCG | ◯ Yes ◯ No | | Mumps | ◯ Yes ◯ No | |
| Varicella | ◯ Yes ◯ No | | Measles | ◯ Yes ◯ No | |
| HPV (Gardasil) | ◯ Yes ◯ No | | Rubella | ◯ Yes ◯ No | |
| Hepatitis A | ◯ Yes ◯ No | | Polio | ◯ Yes ◯ No | |
| | | | | | |
| | | | | | |

**Past medical history:** Please tick all that apply

| | | | |
|---|---|---|---|
| Adrenal dysfunction | ◯Yes ◯No | Irregular heart rhythm | ◯Yes ◯No |
| Alzheimers disease | ◯Yes ◯No | Kyphosis | ◯Yes ◯No |
| Anorexia or Bulimia | ◯Yes ◯No | Liver dysfunction | ◯Yes ◯No |
| Anxiety disorder | ◯Yes ◯No | Kidney failure or disfunction | ◯Yes ◯No |
| Arthritis | ◯Yes ◯No | Mania | ◯Yes ◯No |
| Asthma | ◯Yes ◯No | Muscular dystrophy | ◯Yes ◯No |
| Autoimmune disease | ◯Yes ◯No | Miocardial Infarction (Heart attack) | ◯Yes ◯No |
| Bipolar disease | ◯Yes ◯No | Narcolepsy | ◯Yes ◯No |
| Bleeding disorder | ◯Yes ◯No | Obstructive sleep apnoea | ◯Yes ◯No |
| Cataracts | ◯Yes ◯No | Organ transplant | ◯Yes ◯No |
| Cerebrovascular accident (Stroke) | ◯Yes ◯No | Osteoporosis | ◯Yes ◯No |
| Chemotherapy | ◯Yes ◯No | Painful periods | ◯Yes ◯No |
| Chronic bronchitis | ◯Yes ◯No | Pancreatitis | ◯Yes ◯No |
| Claudication | ◯Yes ◯No | Periodic limb movement disorder | ◯Yes ◯No |
| Clotting disorder | ◯Yes ◯No | Peripheral artery disease | ◯Yes ◯No |
| Congenital heart defects | ◯Yes ◯No | Personality disorder | ◯Yes ◯No |
| Coronary artery disease | ◯Yes ◯No | Pituitary dysfunction | ◯Yes ◯No |
| COPD | ◯Yes ◯No | Polycystic Ovarian Syndrome | ◯Yes ◯No |
| Cystic fibrosis | ◯Yes ◯No | Prostate problems | ◯Yes ◯No |
| Depression | ◯Yes ◯No | Pulmonary Artery Hypertension | ◯Yes ◯No |
| Diabetes | ◯Yes ◯No | Pulmonary fibrosis | ◯Yes ◯No |
| Dialysis | ◯Yes ◯No | Radiation therapy | ◯Yes ◯No |
| Eclampsia or pre-eclampsia | ◯Yes ◯No | Recurrent infections | ◯Yes ◯No |
| Endocarditis | ◯Yes ◯No | Restless Leg Syndrome | ◯Yes ◯No |
| Endometriosis | ◯Yes ◯No | Sarcoidosis | ◯Yes ◯No |
| End stage renal disease | ◯Yes ◯No | Schizophrenia | ◯Yes ◯No |
| Erectile dysfunction | ◯Yes ◯No | Scleroderma | ◯Yes ◯No |
| Esophageal dysfunction | ◯Yes ◯No | Scoliosis | ◯Yes ◯No |
| Fibromyalgia | ◯Yes ◯No | Seizure disorder | ◯Yes ◯No |
| Gallstones | ◯Yes ◯No | Sickle cell anaemia | ◯Yes ◯No |
| Gastritis or gastric ulcers | ◯Yes ◯No | Sjogrens disease | ◯Yes ◯No |
| GERD (or reflux problems) | ◯Yes ◯No | Skin disorders (Psoriasis, acne etc) | ◯Yes ◯No |
| Glaucoma | ◯Yes ◯No | Thalassemia | ◯Yes ◯No |
| Heart or valve defects | ◯Yes ◯No | Thrombocytopenia | ◯Yes ◯No |
| Hemochromatosis | ◯Yes ◯No | Thrombophilia | ◯Yes ◯No |
| Haemorrhoids (Piles) | ◯Yes ◯No | Transfusions | ◯Yes ◯No |
| Hepatitis | ◯Yes ◯No | Tuberculosis | ◯Yes ◯No |
| HIV or AIDS | ◯Yes ◯No | Urinary retention or urgency | ◯Yes ◯No |
| Hypertension | ◯Yes ◯No | Vasculitis | ◯Yes ◯No |
| Hyperthyroidism | ◯Yes ◯No | Visual defects | ◯Yes ◯No |
| Hypotension | ◯Yes ◯No | Cancer – if yes, please provide details | ◯Yes ◯No |
| Hypothyroidism | ◯Yes ◯No | | |
| Inflammatory bowel disease | ◯Yes ◯No | | |

## In the last 6 months, have you experienced any of the following symptoms?

| **Constitutional** | | **Mental** | |
|---|---|---|---|
| Weight loss or gain | ◯Yes ◯No | Anxiety without clear explanation | ◯Yes ◯No |
| Appetite changes (increase or decrease) | ◯Yes ◯No | Sadness lasting for days or weeks | ◯Yes ◯No |
| Fatigue | ◯Yes ◯No | Hearing voices | ◯Yes ◯No |
| Fever | ◯Yes ◯No | Thoughts of hurting yourself | ◯Yes ◯No |
| Shakes/sweats from lack of alcohol or drugs | ◯Yes ◯No | Thoughts of hurting others | ◯Yes ◯No |
| **Eyes** | | Fear of people, places or things | ◯Yes ◯No |
| Eye pain or drainage | ◯Yes ◯No | **Genitourinary** | |
| Visual changes | ◯Yes ◯No | Blood in your urine | ◯Yes ◯No |
| Dry, irritated eyes | ◯Yes ◯No | Menstrual changes | ◯Yes ◯No |
| **Ear, nose and throat** | | Urinating that is painful or difficult | ◯Yes ◯No |
| Ear pain or drainage | ◯Yes ◯No | Erection problems | ◯Yes ◯No |
| Frequent sinus infections | ◯Yes ◯No | Vaginal discharge or bleeding | ◯Yes ◯No |
| Hearing changes or loss | ◯Yes ◯No | **Musculoskeletal** | |
| Nosebleeds | ◯Yes ◯No | Broken bones | ◯Yes ◯No |
| Dizziness | ◯Yes ◯No | Joint pain or swelling | ◯Yes ◯No |
| Hay fever | ◯Yes ◯No | Muscle aches | ◯Yes ◯No |
| **Respiratory** | | Muscle weakness | ◯Yes ◯No |
| Blood in your sputum | ◯Yes ◯No | Back pain | ◯Yes ◯No |
| Chest tightness | ◯Yes ◯No | **Skin/Breasts** | |
| Cough lasting >1 month, productive or not | ◯Yes ◯No | Masses or lumps | ◯Yes ◯No |
| Shortness of breath | ◯Yes ◯No | Nipple discharge | ◯Yes ◯No |
| Wheezing | ◯Yes ◯No | Rashes | ◯Yes ◯No |
| Chest pain with inhalation or coughing | ◯Yes ◯No | Moles that are new or changed | ◯Yes ◯No |
| **Cardiovascular** | | Non healing ulcers | ◯Yes ◯No |
| Chest pain or heaviness | ◯Yes ◯No | **Neurologic** | |
| Palpitations | ◯Yes ◯No | Seizures | ◯Yes ◯No |
| Fainting or near fainting spells | ◯Yes ◯No | Coughing or choking with swallowing | ◯Yes ◯No |
| Swelling of feet or legs | ◯Yes ◯No | Excessive daytime sleepiness | ◯Yes ◯No |
| Shortness of breath lying flat in bed | ◯Yes ◯No | Pain or burning sensation in the hands or feet | ◯Yes ◯No |
| **Gastrointestinal** | | Hallucinations | ◯Yes ◯No |
| Abdominal pain | ◯Yes ◯No | Numbness or tingling | ◯Yes ◯No |
| Blood in your stool | ◯Yes ◯No | Difficulty falling or staying asleep | ◯Yes ◯No |
| Constipation | ◯Yes ◯No | **Endocrinologic** | |
| Diarrhoea | ◯Yes ◯No | Hair loss | ◯Yes ◯No |
| Food intolerance | ◯Yes ◯No | Frequent urination | ◯Yes ◯No |
| Heartburn or indigestion | ◯Yes ◯No | Increased thirst | ◯Yes ◯No |
| Vomiting or nausea lasting > 1 day | ◯Yes ◯No | Heat or cold intolerance | ◯Yes ◯No |
| Difficulty swallowing | ◯Yes ◯No | **Haematological** | |
| **Allergy/Immune system** | | Bleeding from gums or nose | ◯Yes ◯No |
| Watery eyes | ◯Yes ◯No | Unexplained bruising | ◯Yes ◯No |
| Runny nose | ◯Yes ◯No | Night sweats | ◯Yes ◯No |
| Food intolerance | ◯Yes ◯No | Swollen, painful lymph nodes | ◯Yes ◯No |

The information on this page was reviewed with the patient ☐

**Have you ever had any of the following examinations?**

| Test | Response | Approximate date and reason |
|---|---|---|
| Cervical smear | ◯Yes ◯No | |
| Prostate biopsy | ◯Yes ◯No | |
| Mammogram | ◯Yes ◯No | |
| Colonoscopy | ◯Yes ◯No | |
| ECG | ◯Yes ◯No | |
| Lung function test | ◯Yes ◯No | |
| EEG | ◯Yes ◯No | |
| Bone density test | ◯Yes ◯No | |
| X-Ray / CT Scan / MRI | ◯Yes ◯No | |

**Female Patients only**:

| | | |
|---|---|---|
| Have you ever been pregnant? | ◯Yes ◯No | |
| Number of pregnancies | | |
| Number of live births | | |
| Number of miscarriages / abortions | | |
| Your age at onset of menstruation | | |
| Your age at onset of menopause | ☐ N/A | |
| Have you ever taken birth control pills or had birth control injections? | ◯Yes ◯No | If yes, how long? |
| Have you ever used hormone replacement therapy? | ◯Yes ◯No | If yes, how long? |
| Did you ever had an IUD (Intrauterine device implanted? | ◯Yes ◯No | |
| If you had an IUD, was it removed? | ◯Yes ◯No | If yes, when? |

**Surgical history:**

| Type of surgery or procedure | Date | Name of surgeon / facility |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Tobacco Use history

| | | If yes, describe |
|---|---|---|
| Have you ever smoked? | ◯Yes ◯No | # packs per day<br># years |
| Have you smoked pipes or cigars? | ◯Yes ◯No | # cigars or pipe bowls per day |
| Have you chewed tobacco? | ◯Yes ◯No | |
| Have you quit? | ◯Yes ◯No | If yes, when? |
| Have you considered quitting? | ◯Yes ◯No | Have you set a date? ◯Yes ◯No |
| Have you tried quitting? | ◯Yes ◯No | What was the longest time you quit? |

## Alcohol use history

| | | |
|---|---|---|
| Do you now, or did you once, regularly drink alcohol? | ◯Yes ◯No | # drinks per ◯ day ◯ week |
| Have you ever "blacked out" due to alcohol intake? | ◯Yes ◯No | |
| Have you ever had a drink to prevent the "shakes", "sweats", or developed other problems | ◯Yes ◯No | |
| Have you ever been arrested or ticketed for driving under the influence? | ◯Yes ◯No | |
| Have you been involved in any motor vehicle accidents in the past 12 months? | ◯Yes ◯No | |

## Recreational drug use history

Do you now use, or have you ever used, drugs for recreational purposes? ◯Yes ◯No

If yes, tick all that apply ☐ Amphetamines ☐ Cocaine ☐ Marijuana ☐ Heroin ☐ Inhalants ☐ Other

Describe the method of delivery you choose

☐ Ingestion ☐ Injection ☐ Inhalation

| | |
|---|---|
| Have you quit? | ◯Yes ◯No |
| Have you ever taken drugs to prevent the "shakes", "sweats", or developed other problems? | ◯Yes ◯No |
| Have you ever had a problem with addiction to prescription pain medication or benzodiazepines (like Valium, morphine, etc.)? | ◯Yes ◯No |

## Hepatitis, HIV and STD risk factors

| | |
|---|---|
| Are you sexually active? | ◯Yes ◯No |
| If yes, do you practice birth control? | ◯Yes ◯No |
| What birth control method do you use? (Click all that apply) | Condoms<br>Diaphragm |
| How many sexual partners have you had in the past year? | |
| Have you ever had sex with a person who is the same gender as yourself, bisexual, or anyone who performs sexual favours in exchange for money or drugs? | ◯Yes ◯No |
| Have you ever been diagnosed with a sexually transmitted disease (STD), or were you exposed to a STD during childbirth? | ◯Yes ◯No |
| Do you have any tattoos or body piercings? | ◯Yes ◯No |
| Have you ever received any transfusions of blood or blood products? | ◯Yes ◯No |

☐ The information on this page was reviewed with the patient

Can you perform your own hygiene, dressing, cooking and shopping needs independently? ◯Yes ◯No

Have you ever been in a relationship where you were threatened, hurt or afraid?

◯Yes ◯No

## Family medical history

(M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather, M in front=Maternal, P in front=Paternal)

| Medical problem | Family members affected |
|---|---|
| | Mother |
| | Mother |
| | Mother |
| | Mother |
| | Mother |
| | Mother |

## Referral information

We would appreciate learning how you heard about us

- ☐ Another doctor, nurse, health professional. If so, please specify who: _____
- ☐ Family member or friend who is a patient of this medical centre
- ☐ Family member or friend who is NOT a patient of this medical centre
- ☐ Sign outside your office
- ☐ Brochure / Flyer in my mail box
- ☐ Newspaper / magazine advertisement
- ☐ Telephone book
- ☐ Internet
- ☐ Immigration consultant
- ☐ Other, *please specify*

Additional information that you may feel may be helpful for the doctor to know

Signature: _____ Submit by Email Print Form

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