

Health Questionnaire

Patient Name: _____

NHI no. _____

This questionnaire will provide us with an overview of your general health. Please return this form to the GP or the Practice Nurse.

Health Screen

Smoking

- Current smoker
 Trying to stop
 Stopped in the last 12 months Date: _____
 Stopped more than 12 months ago Date: _____
 Never

Alcohol

How often do you have a drink containing alcohol?

- Never
 Once per month (or less)
 2 – 4 times per week
 4 – 5 times per week
 6 – 7 times per week

How often do you have 6 or more drinks on one occasion?

- Never
 Less than monthly
 Monthly
 Once or twice per week
 Daily

How many standard drinks containing alcohol do you have on a typical day when you are drinking? _____

Women

1. If you aged over 20 years:

- Have you ever had a cervical smear **Yes**
 No

- If so where NZ
 Overseas

Date: _____ Result Normal
 Abnormal

2. If you are aged over 45 years:

- Have you ever had a Mammogram **Yes** Date: _____
 No

Allergies to Drugs

Yes

- if so what? _____

No - no known allergies to any drugs

Personal Medical History

Please tick any that apply:

- | | | <i>Office Use Only:</i> |
|---------------------|--------------------------|-------------------------|
| Asthma | <input type="checkbox"/> | #H33 |
| High Blood pressure | <input type="checkbox"/> | #G20 |
| Heart Disease | <input type="checkbox"/> | #G5yX |
| Stroke | <input type="checkbox"/> | #G66.13 |
| Diabetes | <input type="checkbox"/> | #C10 |
| Hepatitis | <input type="checkbox"/> | #A70 |
| Cancer | <input type="checkbox"/> | #B |
| Mental illness | <input type="checkbox"/> | #146 |

Any other significant illnesses, injuries, or operations
- if so what? _____

No significant illnesses, injuries, or operations

Family Medical History

Have any of your parents, grandparents, brothers, sister, aunts or uncles had any of the following medical conditions?

Please tick any that apply:

- | | | <i>Office Use Only:</i> |
|---------------------|--------------------------|-------------------------|
| Asthma | <input type="checkbox"/> | #12D2 |
| High Blood pressure | <input type="checkbox"/> | #12C1 |
| Heart Disease | <input type="checkbox"/> | #12C |
| Stroke | <input type="checkbox"/> | #12C4 |
| Diabetes | <input type="checkbox"/> | #1252 |
| Cancer | <input type="checkbox"/> | #124 |
| Mental illness | <input type="checkbox"/> | #146 |

No Family History of significant illness #122

#14Z1