

Symonds Street Medical Centre Health Questionnaire

Please answer as fully as possible. Please ask for help to fill in the form if needed.

PERSONAL DETAILS

Family Name Gender ☐ Male ☐ Female
First Name (s) Date of Birth
Preferred Name Completed by:

PAST MEDICAL HISTORY: ✓ Have you ever had any of the following?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Depression	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraine
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Addictions
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other	<input type="checkbox"/> Will discuss with Health Professional		

DISABILITY

✓ Do you have a disability? ☐ Yes ☐ No

If yes, please state:

MEDICATION

✓ Do you take any regular medication? ☐ Yes ☐ No If yes, GP will discuss with you.

ALLERGIES

✓ Are you allergic to any tablets, medications or injections? ☐ Yes ☐ No

✓ Do you have any other allergies? ☐ Yes ☐ No

If yes, please state:

What was your reaction When

GENERAL HEALTH QUESTIONS

✓ Have you ever smoked tobacco? ☐ Yes ☐ No Would you like to quit? ☐ Yes ☐ No
✓ If yes, are you? ☐ A current smoker ☐ Ex-smoker (past 12months) ☐ Long term ex-smoker
✓ Do you drink alcohol? ☐ Yes ☐ No How many drinks per session?
If yes, ✓ how often? ☐ Once a month or less ☐ 2 – 4 times a month ☐ 2 -3 times a week ☐ 4 or more times a week
✓ How often do you have more than 6 or more standard drinks per session? ☐ Never
☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

FAMILY HISTORY

✓ Has any immediate family member (mother, father, brother, sister) had any of these conditions/diseases?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	Yes		No				Yes		No	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	Heart Attack ✓	Mother	<input type="checkbox"/>	<input type="checkbox"/>	Stroke ✓	Mother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Osteoporosis		Sister	<input type="checkbox"/>	<input type="checkbox"/>		Sister	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> High Blood Pressure		Father	<input type="checkbox"/>	<input type="checkbox"/>		Father	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Other:			Brother	<input type="checkbox"/>	<input type="checkbox"/>		Brother	<input type="checkbox"/>	<input type="checkbox"/>		

FEMALE PATIENTS ONLY

Complete if applicable

Date of your last cervical smear Result was: Normal ☐ Abnormal ☐

Date of your last mammogram Result was: Normal ☐ Abnormal ☐

Place of Screening: Cervical Smear Mammogram

PAST VACCINATION HISTORY

✓ Have you been vaccinated against Tetanus ☐ No ☐ Yes What year?

Do you have an annual flu vaccination? ☐ No ☐ Yes Date last vaccination

Signature:

Date: