New Patient Medical Questionnaire
For Adults 16 Years & Over

Please complete and submit one form for each **adult** member of your family. If you are unsure how to answer a section or need assistance with completing the form please talk with reception.

* Answers are required for all questions marked with an asterix

Personal Information

Patients Full Name*						
Date of Birth*	/ /					
Email*						
Guardian/Caregiver – Are you completing on behalf of the patient?		Yes	*If yes,* Your Full Name			
	Relationship with Patient				Phone	

Community Services Card*		No		Yes
High User Health Card*		No		Yes

Employment Status* Tick which one applies, if employed:		Employed		Unemployed		Student		Not Applicable
	Occupation							
	Name of Company							
	Address of Company							

Accessibility and Support

Do you need help with mobility/hearing/vision/speaking?*		No		Yes
Please tick all that apply				
◯ Wheelchair	◯ Walking aid	◯ Hearing Aid	◯ Glasses/ Contacts	
◯ Sign language	◯ Lip reading	◯ Braille	◯ Other:	
How else can we help or support you?				

Do you require an interpreter?*		No		Yes
Which language?				

Medication

List any **regular medications or tablets** (including herbal supplements) that you take:					
Are you **allergic** to anything (especially medications)?		No		Yes	*(If yes, please list)*

Medical History

Do you or anyone in your immediate family (parent, sibling, child) currently have or previously had any of the following. Tick all that apply					
	You	Family		You	Family
Diabetes ◯ Type 1 ◯ Type 2 ◯ Unsure			Heart attack or stroke ◯ aged under 50 at time of event ◯ aged 50 & over at time of event		
High blood pressure			Bowel problems or disease		
High cholesterol			Bowel cancer ◯ aged under 55 at time of event ◯ aged 55 & over at time of event		
Heart disease			Other cancer		
Angina			Skin cancer		
Circulation Issues			Blood clots or bleeding disorder		
Mental health illnesses, depression or anxiety			Liver problems or disease (including hepatitis)		
Gout			Asthma		
Reflux			COPD		
Stomach ulcers			Hay fever		
Osteoporosis			Eczema		
Arthritis			Ear or eye problems		
Seizure disorders / epilepsy			Tuberculosis (TB)		
Kidney problems or disease			Thyroid disease		
Breast cancer			Migraine headaches		
Prostate cancer			Multiple sclerosis		
Surgeries or operations?					
Other conditions/ comments:					

Screening - Women

If 25 years or older, have you ever had a **cervical smear?**		No		Yes		Don't know
Have you ever had an **abnormal smear**?		No		Yes		Don't know
Have you had a **hysterectomy** and been told you no longer need smears?		No		Yes		Don't know
If over 45 years, have you had a **mammogram**?		No		Yes		Don't know
If aged between 45 and 69 years are you enrolled in the **National Breast Screening Programme**?		No		Yes		Don't know
If not enrolled in the free Breast Screening Service and are eligible, do we have your **consent to enrol you** on this programme?		Yes		No, I decline to enrol		

Screening - Men

Do you know when your last **mens' health check up** was?		Don't know	*(Date, Year)*

Immunisations

When was your last **Tetanus booster**?		Don't know			*(Date, Year)*	
Are your childhood **immunisations** up to date?		No		Yes		Don't know
Have you received the **human papilloma virus (HPV)** vaccine?		No		Yes		Don't know
Have you received the **MMR** vaccine?		No		Yes		Don't know
Have you received the most recent **Flu** vaccine?		No		Yes		Don't know
Have you received a **Covid-19** vaccine?		No		Yes		Don't know

Lifestyle

Physical Activity	How often do you exercise?	◯ Daily		◯ Once weekly		
		◯ 2-3 times per week		◯ Less than once weekly		
	Do you think your exercise is:	◯ Light	◯ Moderate	◯ Strenuous		
Smoking/ Vaping What is your current status? **Tick all that apply**	◯ **Never smoked / not applicable**					
	◯ **Ex-smoker**	What year did you start smoking/vaping?				
		Average number of cigarettes smoked per day?				
	◯ **Current Smoker**	Year you started smoking				
		Average cigarettes smoked per day				
		Do you consent for our staff to refer you to the Quit service?		Yes		No
	◯ **Current vaper**					
Alcohol Intake	How often do you have a drink containing alcohol?	◯ Never ◯ Monthly or less ◯ 2-4 times per month		◯ 2-3 times per week ◯ 4-5 times per week ◯ 6-7 times per week		
	How many drinks containing alcohol do you have on a "typical day" when drinking?	◯ 1-2 drinks ◯ 3-4 drinks ◯ 5-6 drinks		◯ 7-8 drinks ◯ 10 or more drinks		
	How often do you have 6 or more drinks on one occasion?	◯ Never ◯ Less than monthly ◯ Monthly		◯ Weekly ◯ Daily or almost daily		
	Do you have concerns about your drinking?			Yes		No
Other Substance Use	Do you use any of the following substances?	◯ Cannabis ◯ Methamphetamine		◯ Cocaine ◯ Other		
		If Other, please state:				
	Do you have concerns about substance abuse?			Yes		No

Social Situation

Living Situation	What is your living situation today?	◯ I have a steady place to live ◯ I have a place to live today, but I am worried about losing it in the future ◯ I do not have a steady place to live (I am temporarily staying with others, in a shelter, motel, hotel, in a car or on the street)				
	Do you have concerns about any of the following problems in the place you are currently living? **Select all that apply**	◯ Pests (bugs, ants, mice) ◯ Mould ◯ Lack of heat	◯ Water leaks ◯ None of the above ◯ Other			
		If Other, please state:				
Food Availability	In the past 12 months have you worried that your food might run out before you had money to buy more?		◯ Never ◯ Sometimes ◯ Often			
Transportation	In the past 12 months has lack of reliable transportation kept you from medical appointments, meetings, work or getting things needed for daily living?			◯	Yes	◯ No