Patient Medical Questionnaire

The relationship between The Doctors Ti Rakau and a patient is built on trust, honesty and sharing of information. We kindly ask that you complete this questionnaire as much as possible, as this will help us to identify and serve your medical needs in the best possible way.

Please circle No or Yes where applicable

NAME: _____

CHART NO: _____

Medications

Please list any medications you are currently taking.		
Are you allergic to any medications?	**No**	**Yes** (please list)

Medical History

Do you have any long-term illness or disability? (E.g. heart disease, diabetes, asthma, depression, eczema etc.)	**No**	**Yes** (please list)
Have you been in hospital for any illness OR been treated at home for any serious illness?	**No**	**Yes** (please list)
Have you ever seen a specialist about a medical issue?	**No**	**Yes** (please list)
Apart from any illness referred to above, have you ever had any special tests? (E.g. gastroscopy, cardiograph etc.)	**No**	**Yes** (please list)
Have you, or your family, had any infectious diseases? (E.g. hepatitis B, hepatitis C, HIV, tuberculosis etc.)	**No**	**Yes** (please list)

Lifestyle Information

Are you childhood immunisations up to date? Date of last tetanus booster?	**No**	**Yes**	**Date** _____
Are you a current smoker of tobacco?	**No**	**Yes**	**Number per day** _____ **If yes would you like help to quit smoking Yes** ☐ **No** ☐
Have you ever smoked tobacco?	**No**	**Yes**	**Number per day** _____ **Year ceased smoking** _____

Do you consume alcohol?	**No**	**Yes**	**_____ drinks per day/week**
Do you take recreational drugs? (E.g. cannabis, heroin, methamphetamine, party pills)	**No**	**Yes**	**Yes** (please list)
Do you or anyone in your family have a problem with gambling?	**No**	**Yes**	**Yes** (please list)

Family History

Have any of your blood relatives suffered any of the following? Please state which relative (i.e. mother, father, brother, aunt etc. and the approximate age of diagnosis of the illness) if your answer is yes.

Heart disease under the age of 65	**No**	**Yes**
Diabetes	**No**	**Yes**
Stroke	**No**	**Yes**
Asthma	**No**	**Yes**
Bowel cancer	**No**	**Yes**
Breast cancer	**No**	**Yes**
Other cancers	**No**	**Yes**
Glaucoma	**No**	**Yes**
Any other inherited disease	**No**	**Yes**

Female Patients

Do you have any children?	**No**	**Yes** **What year were they born? _____** **_____**
Have you had any other pregnancies?	**No**	**Yes** (please specify)
Are you taking any contraception?	**No**	**Yes** (please specify)
When was your **last cervical smear** test?	**Year _____**	
Have you ever had treatment to your cervix?	**No**	**Yes** (please specify)
When was your **last mammogram**?	**Year _____**	
Have you ever had a follow-up or treatment after a mammogram screening?	**No**	**Yes** (please specify)

NURSE TO COMPLETE

Height: _____ Weight: _____ BP: _____ Waist circumference: _____

Is CDVRA appropriate? ☐ **No** ☐ **Yes, proceed to assess**