MANA MEDICAL CENTRE

Pre Appointment Questionnaire

Name*	Surname/Family Name	First/Given Name	
	Title	Preferred Name	
Birth Details*	Day / Month / Year of Birth		
Address*	House number and Street Name	Suburb	Town/City/Postcode
Contact Details*	Mobile Phone		
	Email address		
Next of Kin/ Emergency contact*	Name	*Relationship:*	*Phone:*
Do you permit us to contact you by text or email for things such as appointment reminders/results? **Text: Yes ☐ No ☐ Email: Yes ☐ No ☐**			
Please specify your Preferred Pharmacy for all prescriptions:			
Current GP			
Please tick if you DO NOT want a copy of the letter to be sent to your current GP ☐			
Current Medical Centre			

Please circle No or Yes where applicable

Medications

Please list any medications you are currently taking.		
Are you allergic to any medications?	**No** ☐	**Yes** (please list and specify type of allergy) ☐
Are you currently taking any over the counter supplements eg: vitamins or other	**No** ☐	**Yes** (please list) ☐

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Medical History

What are your main concerns regarding perimenopause/menopause?	(please list)	
Have you had a hysterectomy?	**No** ☐	**Yes** ☐
Do you have a history of endometriosis?	**No** ☐	**Yes** ☐
Have you, or a close family relative (ie parent, sibling) ever had breast cancer? If so what age were you/they when first diagnosed?	**No** ☐	**Yes** (please list) ☐
Any additional information that you feel may be helpful for us to know?	**No** ☐	**Yes** (please list) ☐

When was your **last cervical smear test in New Zealand?**	**Year:**	
Have you ever had an abnormal smear or 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) ☐

☐ **I understand that any information provided by me will be confidential in terms of the Health Information Privacy Act**

☐ **I understand Mana Medical Centre is seeing me as a casual patient**

☐ **I understand payment is required on the day of consultation**

Signatory Details	Signature	Day / Month / Year

Once completed please send to admin@manamedical.co.nz
Thank you