MANA
MEDICAL CENTRE

# New Patient Questionnaire

*The relationship between Mana Medical Centre 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.*

**NAME:** ______________________________ **DOB:** ____________

*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) |

## 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) |

## 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** |
| Asthma | **No** | **Yes** |
| Stroke | **No** | **Yes** |
| Bowel cancer | **No** | **Yes** |
| Breast cancer | **No** | **Yes** |
| Other cancers | **No** | **Yes** |

| Glaucoma | **No** | **Yes** |
|---|---|---|
| Any other inherited disease | **No** | **Yes** |

## Lifestyle & Social Information

| | | | |
|---|---|---|---|
| Have you ever vaped? | **No** | **Yes** ➡ | **Year ceased vaping:** |
| Are you currently vaping?<br>*Best thing for your health is to quit.* | **No** | **Yes** ➡ | With Nicotine? **No / Yes**<br>Do you want help to quit? **No / Yes** |
| Are you a current smoker of tobacco?<br>*Best thing for your health is to quit.* | **No** | **Yes** ➡ | Do you want help to quit? **Yes / No** |
| Have you ever smoked tobacco? | **No** | **Yes** ➡ | **Year ceased smoking:** |
| Do you consume alcohol?<br>*A standard = 330ml Beer (4% alcohol) , 100ml Wine (12.5% alcohol) and 30ml spirit (42% alcohol).* | **No** | **Yes** ➡ | **_________ How many days of the week do you consume alcohol**<br>**_________Approx. standard drinks per day** |
| Do you take recreational drugs? E.g. cannabis, heroin, party pills, methamphetamine, ecstasy | **No** | **Yes** (please list) | |
| Do you have any children? | **No** | **Yes** | **What year were they born?** |
| Please list family members whom you live with | | | |
| Are you taking or using any contraception? | **No** | **Yes** (please specify) | |
| Do you exercise? | **No** | **Yes** (please specify) | |
| Do you currently have any home supports in place? (Eg personal cares such as showering, assistance taking your<br>medications, blister packed medication) | **No** | **Yes** (please specify) | |
| Do you have a current Advanced Care Plan (ACP)? | **No** | **Yes** (please ensure we have a copy on file) | |
| Do you have an EPOA (Enduring Power of Attorney) in place? | **No** | **Yes** (please provide details) | |

## Vaccinations

| | | |
|---|---|---|
| Last Tetanus Vaccination | **Year or age given:** | |
| Childhood Vaccinations | **Given in NZ** | **Given Overseas** |
| Other Vaccinations (eg: Travel) | | |

## Female Patients

| | | |
|---|---|---|
| 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) |