NEW PATIENT HEALTH QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH: / /**

GENDER: Male/ Female/Transgender

Do you identify as being: Aboriginal: Yes/No Torres Strait Islander: Yes/No

SOCIAL HISTORY

What is your living situation? (with spouse, family, housemates, alone)		
Do you have any children? If so, how many? Do they still live at home?		
Do you have local family support?		
Have you ever served in the Australian Defence Forces? Please specify (Army, Navy, Air Force, Reserves etc.)		
Do you have Private Health Insurance? If so, with which fund, and what level is your cover?	**Fund:**	**Top/ Intermediate / Basic**

MEDICAL/ FAMILY HISTORY

Do you have any known allergies to medications, food or insect bites? Yes ☐ (Please list below?) No ☐	
Allergy	
Nature of Reaction	

Have you had any operations? Please specify the type of operation and year performed.

Current Medications (please list, including over the counter medications, vitamins, etc)

If completing this form for a child, are their immunisations up to date? Yes / No

Have you or a family member ever suffered from any of the following?
Please tick or write relatives title, eg. Mother/Father/Sibling/Grandparent

Disease	You	Family Member	Disease	You	Family Member
Heart Condition			Asthma		
High Blood Pressure			Diabetes		
High Cholesterol			Epilepsy		
Thyroid Disease			Osteoporosis		
Mental Health Issues			Stroke		
Bowel Cancer			Breast Cancer		
Prostate Cancer			Cervical Cancer		
Ovarian Cancer			Other Cancer		
Arthritis			Other		

If you answered Yes to any of the above for yourself, please give details and which year the condition was diagnosed:

_____

PLEASE TURN OVER PAGE TO COMPLETE QUESTIONNAIRE

SMOKING **Never Smoked** ☐

Current Smoker (please tick)		How many cigarettes do you smoke in a day? _____ What year did you start smoking? _____ Are you planning on quitting? _____
Ex-Smoker (please tick)		How many cigarettes did you used to smoke in a day? _____ What year did you start smoking? _____ What year did you quit smoking? _____

ALCOHOL **Non Drinker** ☐

How often do you have a drink containing alcohol? (Please circle)		
Never	Monthly or Less	2-4 times per month
2-3 times per week	4 or more times per week	
How many standard drinks do you have on a normal day? (Please circle)		
1 or 2	3 or 4	5 or 6
7 or 9	10 or more	
How often would you have 6 or more drinks on one occasion? (Please Circle)		
Never	Less than monthly	Monthly
Weekly	Daily or almost Daily	
Are you concerned about your drinking? (Please Circle)		
Yes	No	Don't Know

PHYSICAL ACTIVITY

How many days a week do you do at least 20 minutes of vigorous exercise that makes you sweat, puff or pant?							**How many days a week do you 30 minutes of walking or moderate physical activity that increases your heart rate or makes you breath harder than normal?**						
1	**2**	**3**	**4**	**5**	**6**	**7**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

MALE PATIENTS	**FEMALE PATIENTS**
Have you had a prostate check-up? Yes/ No When:	What month and year was your last Cervical Screening? / Was it Normal? Yes/ No

Preferred Method of Contact: Email/ Letter/ Phone/ SMS

I consent to receive recalls and health reminders for immunisations, pap smears, health checks etc by SMS.

YES / NO (Please tick) Signed: _____ Date: _____

DOCTOR TO COMPLETE

Height: _____ Weight: _____

Is patient pregnant? Yes/ No

Is the patient due for any Preventative Screening
Eg. Cervical Screening/Breast Check/Mammogram/Prostate Check/ Bowel Cancer Screening
If so, please list:

_____