HealthHubPROJECT
WELLNESS EDUCATION RESEARCH

*If you require assistance to complete this form, please call our friendly team on **06 358 7282***

New Patient Health Questionnaire

Welcome to the Health Hub Project. This questionnaire is to help us to get to know your medical history. We recommend anybody over the age of 25, or who has a significant medical history to book an introductory New Patient Health check.

PERSONAL DETAILS

Full Name

Address

Phone number

Home phone | Mobile Phone | Work Phone

Date of Birth **Height** **Weight**

Your main or first language spoken/understood

MEDICAL HISTORY

		DATE OF LAST REVIEW	MEDICATION NAME
Respitory			
Asthma/COPD	◯ Yes ◯ No		
Breathing Difficulties	◯ Yes ◯ No		
Cardiac			
Heart Attack/Stroke	◯ Yes ◯ No		
Blood Pressure	◯ Yes ◯ No		
Irregular Heartbeat	◯ Yes ◯ No		
Other	◯ Yes ◯ No		
Diabetes	◯ Yes ◯ No		
Epilepsy	◯ Yes ◯ No		
Cancer	◯ Yes ◯ No		
Thyroid Disease	◯ Yes ◯ No		
Kidney Disease	◯ Yes ◯ No		
Mental Wellness	Discussions regarding the following can be had with your clinical team • Anxiety • Depression • Suicidal Thoughts		

Do you take any other medications not mentioned above?

FEMALE PATIENTS

Aged 20-70 yrs (date of last smear)

Aged 45-70 yrs (date of last mammogram)

OR please state if you DECLINE to have them

ALL PATIENTS

Have you had any serious illnesses or operations?
(Please state)

Please tell us if you have any known allergies
(i.e. penicillin, aspirin, plasters, nuts, bee stings etc.)

Do you have a carer? ◯ Yes ◯ No *If yes, who?*

Do you have Social Services help? ◯ Yes ◯ No

Are you registered either partially sighted or blind? ◯ Yes ◯ No *(please state)*

Are you registered with Work and Income? ◯ Yes ◯ No

Do you have any other disabilities? ◯ Yes ◯ No *(please state)*

Have you ever smoked? ◯ Yes ◯ No

Do you currently smoke? ◯ Yes ◯ No ◯ Prefer not to state

How many do you smoke per day?

Would you like help to quit? ◯ Yes ◯ No

Are you exposed to smoke at work? ◯ Yes ◯ No

Are you exposed to smoke at home? ◯ Yes ◯ No

How often do you drink alcohol?
◯ Prefer not to state ◯ Never ◯ Monthly or less
◯ 2 - 4 times per month ◯ 2 - 3 times per week ◯ 4+ times per week

How many glasses of alcohol do you drink on a typical day when you are drinking?
◯ Prefer not to state ◯ 1 - 2 ◯ 3 - 4
◯ 5 - 6 ◯ 7 - 9 ◯ 10+

Is there a history of any of the following in your family (father, mother, brother or sister) before age 65?

DISEASE		WHICH FAMILY MEMBER?
Heart Disease (heart attack, angina)	◯ Yes ◯ No	
Stroke	◯ Yes ◯ No	
Cancer	◯ Yes ◯ No	
Site of Cancer?		

Please list any other concerns that you may wish to discuss with your clinical team.

1.
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3.
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5.

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We are able to offer an online facility via ManageMyHealth to request repeat prescriptions and make general enquiries. To use this facility you will need to be issued with a unique login username and password, please ask our friendly Hosts for information.

Thank you for your time in completing this questionnaire.