FAMILY DOCTORS

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PYES PA · BROOKFIELD · THE LAKES ON OTUMOETAI

ADULT QUESTIONAIRE FOR DATABASE PROFILE (15 Years & Over) **Date: ……../……../……**

Name: …… **D.O.B. ……** **Age: ……**

The following information is requested for inclusion in your records to enable staff to better understand your medical background.

Previous Medical History: *(Please Circle and Tick those that apply)*

Condition	Yes	No	Condition	Yes	No
Asthma / Bronchitis / COPD			Heart Disease		
Arthritis / Joint problems			Hepatitis / Liver problems		
Diabetes			Headaches / Migraines		
Epilepsy / Blackouts			Kidney / Bladder / Prostate problems		
High Cholesterol			Skin problems		
High Blood Pressure			Vision / Hearing / Speech		
BP check in the past 12 months?			Cancer		

List any other significant medical illnesses / injuries / operations / hospital admissions:

_____ Date: _____

_____ Date: _____

_____ Date: _____

What is your family history? *(Tick those that apply)*

Medical History	Father	Mother	Sister	Brother	Children
Diabetes					
Heart Disease					
Stroke					
High blood pressure					
Cancer (specify type)					
Other hereditary illness (specify)					

Current Medical History:

1. **ALLERGIES - Do you have any known allergies(eg- medications, egg)** *Specify type of allergy& describe reaction*

   _____

   _____

2. **ALCOHOL - What is your weekly alcohol intake?** _____

3. **BREAST SCREENING**
   – Do you give consent to be enrolled in the Breast Screening programme for our area? Yes / No / NA
   NOTE: Enrolment in the free programme is for women aged 45-69yrs

SIGNED ……

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