HEALTHZONE MEDICAL HEALTH QUESTIONAIRE

This questionnaire is to help us obtain accurate information for the purpose of health screening and to help us identify issues you may wish to address. If you feel uncomfortable about answering any of the questions, or do not wish to answer them for any reason please leave them blank. The information you give us will be used in strict confidence:

Surname:.....**First Name**:.....

Date of Birth:.....**Occupation**:.....

Social profile: Single/Married/De-facto/Divorced/Widowed

Ages of children:

Your Past Medical History and Current Medical Problems

Tick		Year of Onset
	Diabetes / pre - diabetes	
	Heart Attack / Myocardial Infarction	
	Angina	
	Stroke / TIA	
	DVT / Pulmonary Embolism	
	High Cholesterol	
	High Blood Pressure / hypertension	
	Kidney Disease	
	Depression	
	Joint Disease eg arthritis, osteoporosis	
	Asthma	
	Chronic Lung Disease / Emphysema / Chronic bronchitis	
	Glaucoma	
	Cancer type	
	Skin Cancer type?	
	Other important medical conditions	

Smoking Status information: (15yr and older)

Have you ever smoked? _____ Yes/No. If No, there are no further questions to answer, thank you.

Are you a current smoker?_____ Yes/ No. If YES, the best thing for your health is to quit. Can we help you with this?_____Yes/ No

Are you an Ex- smoker?_____.....Yes/ No. When did you Quit?..... .....

Alcohol: do you drink alcohol? (I unit of alcohol = 100ml wine, 300ml beer, Inip spirits)

No: Never

Yes: Type of drink Units per week

_____ _____

Exercise: Type..... How many times per week?.....

Vaccinations:

Last tetanus Vaccination: (age is sufficient) .....
Child vaccinations up to date? Yes..... No..... Unsure.....

Other vaccinations: (e.g. travel vaccines)
Past operations:

Type of Operation	Year

Regular Medication:

Medication name	Medication dose

Family History:

Tick	Condition	Details	Age of onset	Relationship to you

Allergies (to medication / skin products)

Allergy to	Reaction

Other relevant medical information or other medical problems not covered

For Women: Consent for mammogram results from Breast Screen Aotearoa

Women 45years or older , when was your last mammogram?

I _____give permission for Breast Screening Aotearoa to release my breast screening information to **HealthZone Medical.**

Signed_____Date_____

When and where was your last cervical smear taken? .....
Have you had any abnormal cervical smears?.....

Signed.....**Print Name**.....

Date.....