St Martins Medical Practice Patient Information

NHI #: *(Office Use Only)*	

Full Name:		Date of Birth:	
Occupation:		Employer Details:	
Medical Insurance:	Yes / No	Insurance company:	

I UNDERSTAND THE FOLLOWING:
- NO MEDICATIONS OF ABUSE ARE PRESCRIBED TO NEW PATIENTS
- PAYMENT ON THE DAY OF CONSULTATION IS EXPECTED
- PATIENTS ARE RESPONSIBLE FOR PAYING ANY DEBT FEES INCURRED IF THE ACCOUNT IS NOT PAID BY 28 DAYS OF RECEIVING THE SERVICE

Signature: …….. Date: ……

Health Questionnaire

Do you have any allergies/adverse reactions to anything? (Eg food, medication, pollens)	Yes / No
Details:	
Do you have any medical problems?	Yes / No
Details:	
Have you had any operations?	Yes / No
Details:	
Please list any current medications:	

Do you drink alcohol? If so, how much/week?	
Do you exercise? If so, how often/week?	
Do you smoke? If so, how many/day?	
Have you previously smoked? If so, how many/day?	

Do illnesses run in your family? Details:	
Do you have a family history of premature heart disease?	Yes / No
(Angina or heart attack in mother, father, brother or sister first occurring below the age of 60 or Stroke or TIA occurring at any age)	

Immunisations – Adults: date of last tetanus vaccination + any others eg. Rubella, whooping cough	
Details:	
Immunisations – Children: Fully immunised? (your plunket book will help us with these details)	Yes / No
Details:	

Females

Date of last cervical smear?	Where taken?
Result?	Any previous abnormal results?
Date of last mammogram?	
Family history of above?	