PICTON SURGERY

Medical Questionnaire

Name: **Date of birth:**

Medical conditions:
Do you have, or have you had any of the following medical conditions? Please include family history.

	Self	Family		Self	Family
Diabetes	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart attack – age?	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Lung disease	☐ Yes	☐ Yes	Cancer - breast	☐ Yes	☐ Yes
Respiratory disease	☐ Yes	☐ Yes	Cancer - other	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or related	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression, anxiety, or mental health conditions	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
			Hay Fever	☐ Yes	☐ Yes
Do you have any other health, disability or inherited conditions?	☐ Yes				

Medication, operations: Please list if you have/or had:

			Please list
Regular medications	☐ Yes	☐ No	
Allergic Reactions	☐ Yes	☐ No	
Operations	☐ Yes	☐ No	

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What is your occupation?	

Do you smoke?	☐ Yes	☐ No	How many each per day?
Would you like help to **quit smoking or vaping?**	☐ Yes	☐ No	
Do you vape?	☐ Yes	☐ No	
Do you drink alcohol?	☐ Yes	☐ No	What type?
	If yes,		☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week
Do you use recreational drugs or partake in substance abuse?	☐ Yes	☐ No	Drug/substance type:

Immunisations & Vaccinations:

Are your childhood immunisations up to date?	☐ Yes	☐ No	☐ Don't know
If you received your childhood immunisations overseas, **please provide a copy of your immunisation record.**			
When was your last Tetanus booster?			

Women:

When was your most recent cervical smear?			
Where was this taken?	☐ Overseas	☐ In New Zealand	
Have you ever had an abnormal smear?	☐ Yes	☐ No	☐ Don't know
Have you had a mammogram?	☐ Yes	☐ No	When?
Are you currently pregnant?	☐ Yes	☐ No	Due date?

Signed:_____ **Date:**_____