BROADWAY
MEDICAL CENTRE
2 BROADWAY, DUNEDIN 9016

NEW PATIENT MEDICAL AND HEALTH INFORMATION FORM

Thank you for taking a few moments to fill in this form. Having this information prior to your first appointment will help us get to know you and ensure the smooth running of your consultation

Name: _____ DOB: _____/_____/_____

Family health history: parents and siblings especially, grandparents if known (e.g. heart attack, diabetes, stroke, high blood pressure, cancer). Please list

Personal health history (e.g. mental health, physical illness/conditions - particularly those requiring medication, surgeries, current health concerns) Please list and provide approximate dates if possible, eg high blood pressure since 2015; breast cancer 2003.

Current medications (including supplements): No Yes (please list, including dose)

Allergies (please circle): No Yes (please list allergy and reaction)

Immunisations (please circle):

Did you receive your childhood immunisations? No Yes

Have you had a tetanus booster within the last ten years?

No Yes Year (if known) _____

Screening:

Women aged over 25 years:

Have you had cervical smears in the past? (please circle) No Yes
Year of last cervical smear (if known) _____
Please provide additional information if any abnormal history:
_____

Women aged over 45 years:

Have you had breast screening mammograms? (please circle) No Yes
Where and when did you have your last mammogram (ie region of New Zealand)
_____

Smoking: (Please circle): Never smoked Stopped in _____

Current smoker: how many per day?_ _____ Vaping

Alcohol:

How many days per week do you drink alcohol? _____
How many standard drinks do you have on those days? _____(average)

Recreational drug use: (please circle) No Yes (please list substance and frequency of use)

Activity/exercise:

How active are you currently? (please circle)

Not active Lightly active Moderately active Very active

Additional detail
_____