SUNNYNOOK • MEDICAL CENTRE •

New Patient Medical Questionnaire For ADULTS 16 Years & Over

* Please complete and submit one form for each **adult** member of your family. If you are unsure how to answer a section or need assistance with completing the form please talk with reception.
* Answers are required for all questions marked with an asterix

Personal Information

Patient's Full Name*							
Date of Birth*	/ /						
Email*							
Guardian/Caregiver–Are you completing on behalf of the patient?		Yes	*If yes,* Your Full Name				
	Relationship with Patient				Phone		
Community Services Card*		No		Yes			
High User Health Card*		No		Yes			
Employment Status * (tick which one applies, if employed:)		Employed		Unemployed		Student	Not Applicable
	Occupation						
	Name of Company						
	Address of Company						

Accessibility and Support

Do you need help with mobility/hearing/vision/speaking?*		No		Yes			
Please tick all that apply							
◯ Wheelchair	◯ Walking aid	◯ Hearing Aid	◯ Glasses/Contacts				
◯ Sign language	◯ Lip reading	◯ Braille	◯ Other:				
How else can we help or support you?							

Do you require an interpreter?*		No		Yes
Which language?				

Medication

List any **regular medications** or tablets (including herbal supplements) that you take:					
Are you **allergic** to anything (especially medications)?		No		Yes	*(If yes, please list)*

Medical History

Do you or anyone in your immediate family (parent, sibling, child) currently have or previously had any of the following. Tick all that apply							
	You	**Family**				**You**	**Family**
Diabetes	◯ Type 1 ◯ Type 2 ◯ Unsure			Heart attack or stroke	◯ aged under 50 at time of event ◯ aged 50 & over at time of event		
High blood pressure				Bowel problems or disease			
High cholesterol				Bowel cancer	◯ aged under 55 at time of event ◯ aged 55 & over at time of event		
Heart disease				Other cancer			
Angina				Skin cancer			
Circulation Issues				Blood clots or bleeding disorder			
Mental health illnesses, depression or anxiety				Liver problems or disease (including hepatitis)			
Gout				Asthma			
Reflux				COPD			
Stomach ulcers				Hay fever			
Osteoporosis				Eczema			
Arthritis				Ear or eye problems			
Seizure disorders/epilepsy				Tuberculosis(TB)			
Kidney problems or disease				Thyroid disease			
Breast cancer				Migraine headaches			
Prostate cancer				Multiple sclerosis			
Surgeries or operations?							
Other conditions/comments:							

Screening-Women

If 25 years or older, have you ever had a **cervical smear?**		No		Yes		Don't know
Have you ever had an **abnormal smear**?		No		Yes		Don't know
Have you had a **hysterectomy and** been told you no longer need smears?		No		Yes		Don't know
If over45 years, have you had a **mammogram**?		No		Yes		Don't know
If aged between 45 and 69 years, are you enrolled in the **National Breast Screening Programme**?		No		Yes		Don't know
If not enrolled in the free **Breast Screening Service** and are eligible, do we have your **consent to enrol you on** this programme?		Yes		No, I decline to enrol		

Screening-Men

Do you know when your last **mens' health checkup was?**		Don't know	*(Date, Year)*

Immunisations

When was your last **Tetanus booster**?		Don't know			*(Date, Year)*	
Are your childhood **immunisations up** to date?		No		Yes		Don't know
Have you received the **human papillomavirus (HPV) vaccine?**		No		Yes		Don't know
Have you received the **MMR vaccine?**		No		Yes		Don't know
Have you received the most recent **Flu** vaccine?		No		Yes		Don't know
Have you received a **Covid-19** vaccine?		No		Yes		Don't know

Lifestyle

Physical Activity	How often do you exercise?	◯ Daily		◯ Once weekly			
		◯ 2-3timesper week		◯ Less than once weekly			
	Do you think your exercise is:	◯ Light		◯ Moderate		◯ Strenuous	
Smoking/Vaping What is your current status? **Tick all that apply**	◯ **Never smoked/ not applicable**						
	◯ **Ex-smoker**	What year did you start smoking/vaping?					
		Average number of cigarettes smoked per day?					
	◯ **Current Smoker**	Year you started smoking					
		Average cigarettes smoked per day					
		Do you consent for our staff to refer you to the Quit service?		Yes		No	
	◯ **Current vaper**						
Alcohol Intake	How often do you have a drink containing alcohol?	◯ Never ◯ Monthly or less ◯ 2-4 times per month		◯ 2-3 times per week ◯ 4-5 times per week ◯ 6-7 times per week			
	How many drinks containing alcohol do you have on a "typical day" when drinking?	◯ 1-2 drinks ◯ 3-4 drinks ◯ 5-6 drinks		◯ 7-8 drinks ◯ 10 or more drinks			
	How often do you have6 or more drinks on one occasion?	◯ Never ◯ Less than monthly ◯ Monthly		◯ Weekly ◯ Daily or almost daily			
	Do you have concerns about your drinking?			Yes		No	
Other Substance Use	Do you use any of the following substances?	◯ Cannabis ◯ Methamphetamine		◯ Cocaine ◯ Other			
		If Other, please state:					
	Do you have concerns about substance abuse?			Yes		No	

Social Situation

<table>
<tr><td rowspan="3">Living Situation</td><td>What is your living situation today?</td><td colspan="4">◯ I have a steady place to live
◯ I have a place to live today, but I am worried about losing it in the future
◯ I do not have a steady place to live (I am temporarily staying with others, in a shelter, motel, hotel, in a car or on the street)</td></tr>
<tr><td rowspan="2">Do you have concerns about any of the following problems in the place you are currently living? Select all that apply</td><td>◯ Pests(bugs, ants, mice)
◯ Mould
◯ Lack of heat</td><td>◯
◯
◯</td><td>Water leaks
None of the above Other</td><td></td></tr>
<tr><td colspan="3">If Other, please state:</td></tr>
<tr><td>Food Availability</td><td colspan="2">In the past 12 months have you worried that your food might run out before you had money to buy more?</td><td>◯
◯
◯</td><td>Never
Sometimes
Often</td><td></td></tr>
<tr><td>Transportation</td><td colspan="2">In the past 12 months has lack of reliable transportation kept you from medical appointments, meetings, work or getting things needed for daily living?</td><td></td><td>Yes</td><td></td><td>No</td></tr>
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