

New Patient Questionnaire

The relationship between Courtenay Medical and a patient is built on trust, honesty and sharing of information. We kindly ask that you complete this questionnaire as much as possible, as this will help us to identify and serve your medical needs in the best possible way.

Please circle No or Yes where applicable

NAME: _____

Medications

CHART NO: _____

Please list any medications you are currently taking.		
Are you allergic to any medications?	No	Yes (please list)

Medical History

Do you have any long-term illness or disability? (E.g. heart disease, diabetes, asthma, depression, eczema etc.)	No	Yes (please list)
Have you been in hospital for any illness OR been treated at home for any serious illness?	No	Yes (please list)
Have you ever seen a specialist about a medical issue?	No	Yes (please list)
Apart from any illness referred to above, have you ever had any special tests? (E.g. gastroscopy, cardiograph etc.)	No	Yes (please list)
Have you, or your family, had any infectious diseases? (E.g. hepatitis B, hepatitis C, HIV, tuberculosis etc.)	No	Yes (please list)

Lifestyle Information

Are you a current smoker of tobacco?	No	Yes	Number per day _____
Have you ever smoked tobacco?	No	Yes	Number per day _____ Year ceased smoking _____
Do you consume alcohol?	No	Yes	_____ drinks per day/week
Do you take recreational drugs? (E.g. cannabis, heroin,	No	Yes	Yes (please list)

methamphetamine, party pills, ecstasy).			
Do you or anyone in your family have a problem with gambling?	No	Yes	Yes (please list)

Family History

Have any of your blood relatives suffered any of the following? Please state which relative (i.e. mother, father, brother, aunt etc. and the approximate age of diagnosis of the illness) if your answer is yes.

Heart disease under the age of 65	No	Yes
Diabetes	No	Yes
Stroke	No	Yes
Asthma	No	Yes
Bowel cancer	No	Yes
Breast cancer	No	Yes
Other cancers	No	Yes
Glaucoma	No	Yes
Any other inherited disease	No	Yes

Female Patients

Do you have any children?	No	Yes What year were they born? _____ _____
Have you had any other pregnancies?	No	Yes (please specify)
Are you taking any contraception?	No	Yes (please specify)
When was your last cervical smear test?	Year _____	
Have you ever had treatment to your cervix?	No	Yes (please specify)
When was your last mammogram ?	Year _____	
Have you ever had a follow-up or treatment after a mammogram screening?	No	Yes (please specify)