St Johns Medical Centre

Patient Health Survey

Full Name: _____

Date of Birth: _____ Gender: _____

Do you have private health insurance? _____

Do you have a community services card? Yes/No

Communication and Access

What is your preferred language? English or other

Do you have problems with movement or mobility?

Do you have problems seeing?

Do you have problems hearing?

GENERAL HEALTH

1. Why did you make this appointment (Check all that apply)
   - ☐ Regular check-up
   - ☐ First appointment to start with a new Doctor
   - ☐ Switching Doctors from whom: _____
   - ☐ Have a specific health problem, if so explain_____
     _____

2. In general, what do you consider to be your main health problem(s)? (Check all that apply)
   - ☐ Heart problems
   - ☐ Stomach problems
   - ☐ Ear, nose or throat problems
   - ☐ High blood pressure
   - ☐ Diabetes
   - ☐ Joint problems
   - ☐ Mental health disorders/depression/emotional problems
   - ☐ Other-please explain_____

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3. Are you taking any prescription medicine?
   - ☐ No – go to question 4
   - ☐ Yes – please list below

Name of medicine	Amount/size of pill	How many doses and how often
E.g. Furosemide	*20 mg*	*2 morning / 2 night*

4. Have you ever had any allergic reaction (bad effects) to a medicine or shot?
   - ☐ No - go to question 5
   - ☐ Yes - please list

Medicine I am allergic to	What happens when I take the medicine
E.g. Atenolol	*I get a rash*

5. Do you get an allergic reaction (bad effect from any of the following? (Check all that apply)
   - ☐ Latex
   - ☐ Grass or pollen
   - ☐ Eggs
   - ☐ Shellfish
   - ☐ Peanuts
   - ☐ Other (please describe) _____

6. Have you ever had a colonoscopy?
   - ☐ No
   - ☐ Yes, when_____

7. Have you ever received a blood transfusion
   - ☐ No
   - ☐ Yes, when_____

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FOR WOMEN ONLY

8. Have you ever been pregnant
   - ☐ No
   - ☐ Yes, how many times? _____

   How many children have you given birth to? _____

9. Have you had a PAP smear
   - ☐ No
   - ☐ Yes, date of last one_____

10. Have you ever had a PAP smear that was not normal
    - ☐ No
    - ☐ Yes

11. Have you ever had a mammogram
    - ☐ No
    - ☐ Yes, date of last one_____

SHOTS

12. When was your last Tetanus Shot? _____

13. When was your last Pneumonia shot? _____

14. When was your last flu shot? _____

15. Please list any other shots you have had and when_____

SOCIAL HISTORY

16. Please state your highest education? _____

17. How well can you read
    - ☐ Very Well
    - ☐ Not well
    - ☐ I cannot read

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18. Please chose your current residency status
    - □ I am a New Zealand citizen
    - □ I hold a resident visa
    - □ I am an Australian Citizen or Australian permanent resident
    - □ I have a work visa/permit
    - □ I am an interim visa holder
    - □ I am a refugee

19. Have you ever vaped, smoked cigarettes, cigars, used snuff or chewed tobacco?
    - □ No – go to question 20
    - □ Yes
        - o When did you start? _____
        - o How much per week? _____
        - o Have you quit? _____when_____
        - o Do you want to quit? _____

20. Do you drink alcohol?
    - □ No – go to question 21
    - □ Yes
        - o Have you ever felt you need to cut down on your drinking? _____
        - o Have people ever annoyed you by criticising your drinking? _____
        - o Have you ever felt bad or guilty about your drinking? _____
        - o Have you ever had a drink first thing in the morning? _____

21. Do you have any beliefs or practices from your religion, cultural, or otherwise that the doctor should know?
    - □ Due to my religious beliefs, I do not accept blood/blood products
    - □ I do not use birth control because of personal or religious beliefs
    - □ I fast (go without food) for periods of time for personal or religious beliefs
    - □ I am a vegetarian (do not eat meat)
    - □ I am a vegan (do not eat anything that comes from an animal)
    - □ Other special diets or eating habits (please describe) _____
    - □ I use traditional medicines or treatments, such as acupuncture or herbs
    - □ Other beliefs_____

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22. Do you use any of the following to help you walk?

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Other_____

23. In the past year, have you ever been emotionally or physically abused by a partner or someone important to you?

- ☐ Yes
- ☐ No

24. Exercise (Please fill in table below)

Describe what kind of exercise you do (check all that apply)	How many days per week do you exercise?	For how long do you exercise each day?
☐ Walking	☐ Once per week	☐ Less than 15 minutes
☐ Biking	☐ twice per week	☐ 15-30 minutes
☐ Swimming	☐ 3 times a week	☐ 30-45 minutes
☐ Weight training	☐ 4 times a week	☐ 45minutes-1 hour
☐ Yoga	☐ 5 times a week	☐ Over 1 hour
☐ Other	☐ 6 times a week	
☐ I do not exercise	☐ 7 times a week or more	

FAMILY HISTORY

What medical problems do people in your family have? (Please fill in table below)

Family Member	Medical Problems
Mother	☐ Diabetes ☐ High Blood pressure ☐ Heart problems ☐ Cancer ☐ Other_____
Father	☐ Diabetes ☐ High Blood pressure ☐ Heart problems ☐ Cancer ☐ Other_____
Sisters	☐ Diabetes ☐ High Blood pressure ☐ Heart problems ☐ Cancer ☐ Other_____
Brothers	☐ Diabetes ☐ High Blood pressure ☐ Heart problems ☐ Cancer ☐ Other_____

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HISTORY OF MEDICAL CONDITIONS

Have you ever had any of the following conditions? Check all that apply

☐ Anaemia (low iron blood)	☐ Asthma (wheezing)	☐ Diabetes (sugar)
☐ Heart Trouble	☐ Haemorrhoids	☐ Cancer
☐ Hepatitis (yellow jaundice)	☐ Tuberculosis (TB)	☐ Liver Trouble
☐ Pneumonia	☐ Rheumatic fever	☐ Ulcers
☐ Stroke	☐ High blood pressure	☐ skin problems
☐ Depression	☐ Epilepsy (fits, seizures)	☐ Anxiety

☐ DD, STD (syphilis, gonorrhea, Chlamydia, HIV)

☐ Drug/Substance dependency or abuse

☐ Other_____

Information provided is accurate and a true reflection of my health.

Signed: _____

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