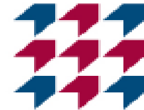
Anglesea Gynaecology



Ph: 07 858 0757 Fax: 07 838 0366
reception@angleseagynae.co.nz

Health Questionnaire

Please complete this questionnaire and bring it with you to your first consultation

Note that this a legal document please ensure all of the information is true and correct. Take special attention to documenting you legal name. If unsure please ask at reception.

Legal first name/s : ____

Legal surname names/s : ______________________________ *(Required for blood taking)*

DOB: ___ /___ /___ Height: __________ ft-in/cm

Weight: __________ kg's BMI: __________

Please list your medications: *(including Over the Counter/Herbal)* ______________________

____

Do you have any allergies/sensitivities: *(i.e.. Medication)* YES/NO
(Please list, and state type of reaction)

____

Food / Other allergies or sensitivities: *(i.e.. Plaster)* YES/NO
(Please list, and state type of reaction)

____

Do you have any of the following medical conditions: *(please tick where appropriate)*

Asthma _____ Diabetes _____

Heart Attack/s or Cardiac Conditions _____ Hypertension _____

Bleeding disorder _____ *(Please list)* ________________________________

MRSA (methicillin resistant staphylococcus aureus) _____

Hepatitis A/B/C _____ Respiratory Conditions _____

HIV _____ Stroke _____

Migraines _____ Epilepsy _____

Other ____

Gynaecological conditions: *(please tick where appropriate)*

Polycystic Ovaries _____ Endometriosis _____

Abnormal smears _____ *(If you have had treatment please list)* _______________________________

Have you received the Gardisil immunisation? YES/NO

Previous surgeries: *(please list all surgeries including year)*

____

____

Do you require an interpreter? YES/NO

Do you have a hearing loss? YES/NO

Do you wear hearing aids? YES/NO

Do you have any loss of vision? YES/NO

Do you wear glasses? YES/NO

Have you ever had a history of problems with anaesthetics? YES/NO

Please explain further ____

____

____

Signature: ____________________ Date: _____ /_____ /_____