DR SANMARIE DUDDRIDGE MBChB, FRACP

Consultant Physician & Geriatrician

New Patient Health Questionnaire

The following questionnaire will help us to better assess your health and help get the most out of your visit.

Your information:

Name: ______________________________

Date of Birth: ______________________________

Date: ______________________________

Briefly describe what you see if your main problem or concern?

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When did it start? ______________________________

How did it progress? ______________________________

How is it effecting your life or what are you not able to do as a result of it?

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Please list any other information about your health, questions you might have or important issues you want to discuss during your visit

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Tell us about yourself:

What are your current activities or hobbies?	
Are you currently married or have a partner?	
Do you have any children? If so, how many and where are they located?	
Are you currently working or retired?	
What occupation did/do you spend most of your time doing?	
What is your highest level of education completed?	
What type of residence do you live in?	
Do you live with anyone?	
Who would help you in an emergency?	
Which social supports do you have?	
Have you had an assessment by the "Aged Care Assessment Team" done?	
Please describe any community support services you are receiving and from who?	

Personal Habits

Do you drink alcohol	Yes ☐	No ☐
How many units per week?		
Do you smoke or have you smoked in the past?	Yes ☐	No ☐

Planning for the future

Do you have a Will?	Yes ☐	No ☐
Do you have an Advanced Health Directive?	Yes ☐	No ☐
Have you appointed an Enduring Power of Attorney?	Yes ☐	No ☐
Who did you appoint as your enduring power of attorney		

Medical History

Do you have any of the following medical conditions?			
			Comments
Diabetes	Yes ☐	No ☐	
High blood pressure	Yes ☐	No ☐	
High Cholesterol	Yes ☐	No ☐	
Heart disease	Yes ☐	No ☐	
Stroke	Yes ☐	No ☐	
Memory problems	Yes ☐	No ☐	
Lung problems	Yes ☐	No ☐	
Kidney disease	Yes ☐	No ☐	
Arthritis	Yes ☐	No ☐	
Osteoporosis	Yes ☐	No ☐	
Eye problems	Yes ☐	No ☐	
Other:			

Other Specialists

Please list any Specialists you see

Vaccinations

Question	Yes	No
Have you had your influenza vaccination this year?	Yes ☐	No ☐
Have you had a vaccine to protect you against Pneumococcus?	Yes ☐	No ☐
Have you had a Zoster/Shingles vaccination?	Yes ☐	No ☐

My medications

Please list all current medications, over the counter medications and vitamins you take		
How do you remember to take your medications?		
Do you have a Webster Pack/ Medication Roll or equivalent?	Yes ☐	No ☐

Allergies

Please list any allergies you have

Surgical History

Please list any procedures you have had

Hospitalisations

Please list any hospitalisations you have had in the last 5 years

Family History

Please list any family medical history

Relationship to you	Condition

Review of Systems:

Do you have difficulty driving, watching TV, or reading because of poor eyesight?	Yes ☐	No ☐
Do you have difficulty hearing normal conversational voice?	Yes ☐	No ☐
Do you use hearing aids?	Yes ☐	No ☐
Do you have problems with your memory?	Yes ☐	No ☐
Do you often feel sad or depressed?	Yes ☐	No ☐
Have you unintentionally lost weight in the last 6 months?	Yes ☐	No ☐
Do you have difficulty swallowing or do you cough after food or drinks?	Yes ☐	No ☐
Have you lost your appetite?	Yes ☐	No ☐
Do you have trouble with control of your bladder?	Yes ☐	No ☐
Do you have trouble with control of your bowels?	Yes ☐	No ☐
How many falls have you had in the past year?		
Have you had any fractures in the past 5 years?	Yes ☐	No ☐
Have you had a bone mineral density?	Yes ☐	No ☐
If yes, when was the last scan done		
Do you feel unsafe at home?	Yes ☐	No ☐
Has anyone intentionally tried to harm you?	Yes ☐	No ☐

Activities of Daily Living:

Are you independent, require help, or dependent with each of the following tasks?

Instructions: Please tick or make a cross in the relevant box.

	Independent (I) (can do by myself)	Assistance (A) (need help from another person)	Dependent (D) (cannot do at all)
Walking	☐	☐	☐
Dressing	☐	☐	☐
Bathing	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Shopping	☐	☐	☐
Preparing Meals	☐	☐	☐
Housework	☐	☐	☐
Taking Medications	☐	☐	☐
Managing Finances	☐	☐	☐
Driving	☐	☐	☐

Any other information:

Thank you for your time