# Centennial Health Patient Questionnaire

Name:_____ DOB: ___/___/_____

***Do you suffer /have you suffered from any of the following:***

| | | | |
|---|---|---|---|
| High blood pressures | Yes [ ] No [ ] | Diabetes | Yes [ ] No [ ] |
| Heart disease | Yes [ ] No [ ] | Epilepsy | Yes [ ] No [ ] |
| Asthma | Yes [ ] No [ ] | Migraine | Yes [ ] No [ ] |
| Mental illness of any type | Yes [ ] No [ ] | Kidney problems | Yes [ ] No [ ] |
| Hearing problems | Yes [ ] No [ ] | Bowel problems | Yes [ ] No [ ] |
| Sight problems | Yes [ ] No [ ] | Urinary problems | Yes [ ] No [ ] |
| Arthritis | Yes [ ] No [ ] | Indigestion | Yes [ ] No [ ] |
| Blood problems | Yes [ ] No [ ] | Cancer | Yes [ ] No [ ] |
| Thyroid problems | Yes [ ] No [ ] | Stroke/TIA | Yes [ ] No [ ] |

*Please provide details you feel are relevant to the above*

***Hospital admissions (please list and include dates/operations if possible)***

***Please indicate if you have a family history of stroke or heart disease:***

A. Mother or sister before age 65 Yes [ ] No [ ]
B. Father or brother before age 55 Yes [ ] No [ ]
If Yes give further details

***Do you take any medications? Please use the other side of this sheet to answer this question.*** Include name/dose/frequency (or attach paper from the pharmacy. Which medicines do you purchase without prescription from the pharmacist?

***Do you have any allergies (please state)*** Yes [ ] No [ ]

***Have you ever smoked cigarettes or tobacco?*** Yes [ ] No [ ]
***Are you a smoker now?*** Yes [ ] No [ ] How many per day?
***Would you like advice on how to give up?***

***Do you drink alcohol?*** Yes [ ] No [ ] How much each day?
***How often do you drink at least 6 drinks (female) or 8 drinks (male) on one occasion?***

***Do you have any substance abuse problems?*** Yes [ ] No [ ]

***Women: when was your most recent cervical smear?*** _____
***Have you ever had an abnormal smear?*** Yes [ ] No [ ]

***Are your childhood immunisations up to date?*** Yes [ ] No [ ]
***When was your last tetanus immunisation/booster?*** _____