Pre-Registration Questionnaire
Amuri Community Health Centre

Welcome to the Amuri Community Health Centre. As part of registering with us we ask that you complete the following health questionnaire (one for each family member if appropriate) to enable us to provide you with optimum quality health care. This form will then be reviewed by a Practice Nurse to ensure your individual current and preventative health needs are added to your individual health record.

Please let the receptionist know if English is not your first language and you wish your information to be shared with a family member or friend, who interprets for you.

Name: _____ **DOB:** _____

Immunisations History:
(Overseas patients please provide vaccination documentation)

Last tetanus vaccination: Date: _____ Unknown □

Childhood vaccinations:

6 weeks □ 3 months □ 5 months □
12 months □ 15 months □ 4 years □
11 years □ unknown □

Family history:

Has your mother, father, brother, sister suffered from heart disease, diabetes, cancer, or any other serious health problems?

YES □ NO □

If yes, please specify:

Screening History:

Cervical Screening/HPV Testing:

Last Test (year) _____

Previous **abnormal** test: YES □ NO □

Mammograms (aged 45-70 years):
Consented □ Declined □

Last screening (year) _____

Cholesterol (> 40 years):
Have you ever had your cholesterol checked?
YES □ NO □

If yes, was it high □ normal □ unknown □

Blood Pressure (>40 years):
Have you had your blood pressure checked?
YES □ NO □

If yes, was it high □ normal □ unknown □

Past Medical History:

Have you ever had:

YES □ NO □ Diabetes; if yes, is it controlled by diet / tablets / insulin.
YES □ NO □ Lung Disease; if yes, which one; Asthma / Emphysema / Chronic Bronchitis
YES □ NO □ High blood pressure
YES □ NO □ Heart Disease
If yes, please circle which ones
Angina / Heart Attack / Heart Failure
YES □ NO □ Cancer
YES □ NO □ Depression or mood disorder
YES □ NO □ Thyroid problems
YES □ NO □ Operations
YES □ NO □ Other

If yes, please specify:

Smoking & Alcohol:

Vaping status: Yes □ No □

Smoking status: Never Smoked □
Ex-Smoker □
Current Smoker □

If a smoker - how many per day? _____
Would like smoking cessation to advice & help YES □ NO □

Do you drink alcohol? YES □ NO □
How many alcohol-free nights on average per week? _____
How many units per session? 1-2 □
3-4 □
6+ □

Medications:

Are you allergic to any medications? NO □ YES □

Please list & describe reaction:

Current regular medications: