



New Patient Medical Questionnaire

Date: _____ NHI _____ **Southern Cross Policy No:** _____

Full Name: _____

Address: _____

Telephone: Home _____ Work _____ Mobile _____

Email: _____

Date of Birth: _____ **General Practitioner:** _____

Please list any past or present medical problems or illness: _____

Please list any previous surgery: _____

Please list all current medications (prescription and over the counter items): _____

Please list all allergies and sensitivities including drugs: _____

Occupation: _____ **Smoker:** (yes/no) _____

Next of Kin: _____

Please list all Diseases or illnesses that run in the family: _____

Is there any history of deep vein thrombosis, Pulmonary Embolism or blood clots? (yes/no)

If yes please describe: _____

Are you pregnant or breastfeeding? (yes/no) _____

Do you give consent for Clinic Eleven to collect and retain your patient information? (yes/no)

Digital images are an important part of your medical care. Are you happy for photos to be taken and included in your medical record? (yes/no)

Are you happy for a copy of your medical records and results to go to your GP? (yes/no)

Preferred Contact method: (please circle)

Text Message Email Phone Snail Mail (Post)

Recommended by: Name of friend / Relative / Other _____

Would you like to receive newsletters and details of special offers? **Yes please / No thanks**

Signature: _____ **Date:** _____