HOWICK HOUSE
Medical

PATIENT REGISTRATION FORM

43 MOORE St, HOWICK, AUCKLAND 2014, Ph: 09 535 8797, Fax: 09 535 5665

SELECT A DOCTOR

- ☐ Dr Graeme Kidd
- ☐ Dr Piers Anderson
- ☐ Dr Bronwyn Lloyd
- ☐ Dr Katharine Martin
- ☐ Dr Yaw Moh

Do you want to be a Permanent or a Casual Patient?

☐ PERMANENT ☐ CASUAL

Title:

☐ Mr ☐ Mrs ☐ Miss
☐ Ms ☐ Master ☐ Dr

Family/Surname: First Names:

Residential Address: Home Phone:
Work Phone:
Mobile:

Date of Birth: Place of Birth:

Gender: ☐ Male ☐ Female ☐ Other

Occupation: Work Name:

Work Address:

Please tick applicable:

☐ NZ Citizen ☐ NZ Permanent Resident
☐ Visitor to NZ ☐ Other (please clarify)

Which ethnic group do you identify with?

☐ European/Pakeha NZ ☐ Maori - NZ ☐ Other European
☐ Chinese ☐ Other (please state)

PAYMENT FOR CONSULTATION IS AT TIME OF VISIT

I agree that if my account is not paid in full at the time of consultation,
I will incur an account fee and I am liable for all debt recovery costs.

SIGNED (Patient, Parent or Guardian): Date of Registration:

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MEDICAL QUESTIONNAIRE

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PLEASE COMPLETE THIS WHERE POSSIBLE FOR EACH MEMBER OF THE FAMILY AND HAND IT TO THE DOCTOR

Name: ______ Date of birth: ______

Date: ______

Present Medications: ______

Do you smoke? ☐ Yes ☐ No ☐ Ex smoker ☐ Never

If yes, how many cigarettes per day ? ______

Alcohol? ☐ Yes ☐ No

If yes, approximately how many drinks per week? ______

Allergies: ______

Drugs: ______

Others: ______

CHILDREN

Have they been immunised?

☐ 6 weeks ☐ 3 months ☐ 5 months ☐ 4 years ☐ 11 years ☐ 15 years

PLEASE SUPPLY A COPY OF ALL IMMUNISATION HISTORY

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ADULTS

ALL:

When was your last tetanus injection?

Date:

Do you have any of the following? (Please tick if applicable)

- ☐ Insulin dependant diabetes
- ☐ Hypertension
- ☐ Chronic obstructive lung disease
- ☐ Hepatitis
- ☐ Angina
- ☐ Gynaecological problems
- ☐ Thyroid disease
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Non insulin dependant diabetes
- ☐ Ischaemic Heart Disease
- ☐ Depression
- ☐ Urinary/Renal problems
- ☐ Congestive Heart Failure
- ☐ Breast disease
- ☐ Other: (Please specify)

Family History – has anyone in your family had health problems?

☐ Mother ☐ Father ☐ Other family

Have you had any operations? Please state.

WOMEN:

When was your last cervical smear? Date:

Result: ☐ Normal ☐ Abnormal

When was your last Mammography? Date:

Result: ☐ Normal ☐ Abnormal

Office use only: