WaihiFamilyDoctors

National Hauora Coalition

| **Waihi Family Doctors**<br><br>**Enrolment Form** | **Physical Address:** 43 Kenny Street, Waihi 3610<br>**Postal Address:** PO Box 262, Waihi 3641<br>**Ph:** 07 863 2112<br>**Fax:** 07 863 7728<br>**EDI:** waihidoc |
|---|---|

*** Indicates fields that are COMPULSORY**

| | | | | |
|---|---|---|---|---|
| **Name** | Title | First Name* | Surname/Family Name* | |
| | Middle Name | | Preferred Name | Maiden Name |
| **Birth Details** | Day/Month/Year* | | Place of Birth* | Country of Birth* |
| **Gender** | ☐ Male ☐ Female ☐ Gender Diverse (please specify)* | | | |
| **Usual Residential Address** | House Number and Street Name* | | Suburb/Rural Delivery* | Town/City and Postcode* |
| **Postal Address** *(if different from above)* | House Number and Street Name or PO Box Number | | Suburb/Rural Delivery | Town/City and Postcode |
| **Contact Details*** | Home Phone | | Mobile Phone | |
| | I consent to receiving text messages ☐ Yes ☐ No | | | |
| **Email Address** | | | | |
| **Next of Kin / Emergency** | Name* | Relationship* | Mobile (or other) Phone* | |

| **Ethnicity Details*** | | | | |
|---|---|---|---|---|
| **Which ethnic group(s) to you belong to?** *Tick the space or spaces which apply to you* | ☐ | New Zealand European | **Occupation** | |
| | ☐ | Maori | **Employer** | |
| | ☐ | Samoan | **Employer Address** | |
| | ☐ | Cook Island Maori | **Smoking Status* (applies to 15 years and over)** | |
| | ☐ | Tongan | ☐ Never smoked ☐ Ex-Smoker ☐ Current Smoker | |
| | ☐ | Indian | If you are a current smoker, would you like support to quit? ☐ Yes ☐ No | |
| | ☐ | Other (please state) | **Preferred Pharmacy**<br>☐Clarks ☐Barrons ☐Waihi Beach Chemist ☐Katikati Unichem<br>☐Other (please state) _____ | |

| | |
|---|---|
| **Transfer of Records** | In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.<br>I understand that I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in New Zealand.<br>☐ Yes, please request my transfer of records ☐ No ☐ Not Applicable (e.g. new born baby) |
| | Previous Doctor and/or Practice Name |
| | Practice Address / Location |

**Patient Portal – Manage My Health**
I would like to sign up to Manage My Health and access my records online ☐ Yes ☐ No
*Please note: you will need your own individual email address to access this service*

**FOR OFFICE USE ONLY** **NHI NO:** **ENTERED/COMPLETED BY:** (staff initials)

☐ Photo ID sighted & copied ☐ Address Verified ☐ NES Enrolment ☐ Transfer of Records requested

I intend to use **Waihi Family Doctors** as my regular and ongoing provider of general practice / GP / First Level primary health care services. I am eligible to enrol because I live in New Zealand and meet one of the following criteria:

**Please tick the option that applies** ☑

a) ☐ I am a New Zealand citizen
**OR**

b) ☐ I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)
**OR**

c) ☐ I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years
**OR**

d) ☐ I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included)
**OR**

e) ☐ I am an interim visa holder who was eligible immediately before my interim visa started
**OR**

f) ☐ I am a refugee or protected person **OR** in the process of applying for, or appealing refugee or protection status, **OR** a victim or suspected victim of people trafficking
**OR**

g) ☐ I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above
**OR**

h) ☐ I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder
**OR**

i) ☐ I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old)
**OR**

j) ☐ I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme
**OR**

k) ☐ I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.

☐ **I confirm that I have provided proof of my eligibility**

## My agreement to the enrolment process

**NB. Parent or Caregiver to sign if you are under 16 years**

**I choose to enrol with this practice as my regular and on-going provider of general practice / GP / First Level primary health care services.**

- I understand that by enrolling with this practice I will be enrolled with the National Hauora Coalition, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.
- I understand that if I visit another provider where I am not enrolled I may be charged a higher fee.
- I have been given information about the benefits and implications of enrolment with the PHO, and their contact details.
- I have read and I agree with the Health Information Privacy Statement.
- I agree to inform the practice of any changes in my eligibility.

| | |
|---|---|
| | / / |
| **SIGNATURE** | **DATE** |

**If signed by AUTHORITY (under 16 years) -**

| Full Name of Authority | Contact Phone Number | Relationship |
|---|---|---|
| Detail the basis of authority (e.g. parent of a child under 16): | | |

WaihiFamilyDoctors

Medical Questionnaire **For <u>Adults</u> 16 Years and Over**

Please complete and submit one form for each adult member of your family. If you are unsure how to answer a sedction or need assistance with completing the form please talk with reception.

* Answers are required for all questions marked with an Asterix

## Personal Information

| | | | | | | |
|---|---|---|---|---|---|---|
| Patients full name: | | | | | | |
| DOB: | / / | | | | | |
| Email: | | | | | | |
| Guardian/caregiver - are you Completing on behalf of patient? | YES | | Your full name | | | |
| | Relationship with patient | | | | Phone: | |

| | | | | |
|---|---|---|---|---|
| Community services card* | | No | | Yes |
| High user Health card | | No | | Yes |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Employment Status* Tick which one applies, if employed: | | Employed | | Unemployed | | Student | | Not applicable |
| | Occupation | | | | | | |
| | Employer name | | | | | | |
| | Employer Address | | | | | | |

## Accessibility and Support

| | | | | |
|---|---|---|---|---|
| Do you need help with mobility/hearing/vision/speaking | | No | | Yes |
| *Please tick all that apply:* | | | | |
| O Wheelchair | O Walking aid | O Hearing Aid | O Glasses/contacts | |
| O Sign language | O Lip reading | O Braille | O Other: | |

| | | | | |
|---|---|---|---|---|
| Do you require an interpreter* | | No | | Yes |
| Which language? | | | | |

## Medication

| | | | | | |
|---|---|---|---|---|---|
| List any **regular medications or tablets (***inc herbal***)** that you take: | | | | | |
| Are you allergic to anything (ie medications) | | No | | Yes | (If yes please list) |

## Medical History

Do you or anyone in your immediate family (parent, sibling, child) currently have or previously had any of the following:
*Tick all that apply*

| | You | Family | | You | Family |
|---|---|---|---|---|---|
| Diabetes<br>O Type 1 O Type 2 | | | Heart attack or stroke<br>O <age 50 O >age 50 | | |
| High blood pressure | | | Bowel problems or disease | | |
| High cholesterol | | | Bowel cancer<br>O <age 55 O >age 55 | | |
| Heart disease | | | Other cancer | | |
| Angina | | | Skin cancer | | |
| Circulation issues | | | Blood clots or bleeding disorders | | |
| Mental health illnesses<br>(depression/anxiety etc) | | | Liver problems or disease | | |
| Gout | | | Asthma | | |
| Reflux /GORD | | | COPD | | |
| Stomach ulcers | | | Hayfever | | |
| Osteoporosis | | | Eczema | | |
| Arthritis | | | Ear or eye problems | | |
| Seizure disorders/epilepsy | | | Tuberculosis (TB) | | |
| Kidney problems or disease | | | Thryoid disease | | |
| Breast cancer | | | Migraine headaches | | |
| Prostate cancer | | | Multiple sclerosis | | |

Surgeries or operations?

Other conditions/Comments:

## Screening – Women

| | | | | | | |
|---|---|---|---|---|---|---|
| If 25 year or older, have you had a **Cervical Smear?** | | No | | Yes | | Don't know |
| Have you ever had an **abnormal smear**? | | No | | Yes | | Don't know |
| Have you had a hysterectomy and been told no more smears? | | No | | Yes | | Don't know |
| If >45 years, have you had a **Mammogram?** | | No | | Yes | | Don't know |
| If >45 and <69, are you enrolled in *Breastscreen Aoteoroa*? | | No | | Yes | | Don't know |
| If not enrolled in *Breastscreen Aoteoroa*, and are eligible, do we have your consent to enrol you on this programme? | | Yes | | No, I decline to enrol | | |

## Screening – Men

| | | | |
|---|---|---|---|
| Do you know when your last **men's health** check up was? | | Don't know | (Date/year) |

## Immunisations

| | | | | | | |
|---|---|---|---|---|---|---|
| When was your last **Tetanus** booster? | | Don't know | | | | (Date/year) |
| Are your childhood immunisations up to date? | | No | | Yes | | Don't know |
| Have you received the **human papilloma virus (HPV)** vaccine | | No | | Yes | | Don't know |
| Have you received the **MMR** vaccine? | | No | | Yes | | Don't know |
| Have you received the most recent **flu** vaccine? | | No | | Yes | | Don't know |
| Have you received a **covid-19** vaccine? | | No | | Yes | | Don't know |

## Lifestyle

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Physical activity** | How often do you exercise? | O Daily | | O Once weekly | | | |
| | | O 2-3 x week | | O Less than once weekly | | | |
| | Do you think your exercise is? | O Light | | O Moderate | | O Strenuous | |
| **Smoking/vaping** | O **Never smoked /NA** | | | | | | |
| | O **Ex smoker** | What year did you start smoking/vaping | | | | | |
| | | Average number of cigarettes/day smoked | | | | | |
| | O **Current smoker** | Year you started smoking | | | | | |
| | | Average number cigarettes/day smoked | | | | | |
| | | Do you consent to referral to smoking cessation | | Yes | | No | |
| | **O Current vaper** | | | | | | |
| **Alcohol intake** | How often do you have a drink containing alcohol | O Never | | O 2-3 x week | | | |
| | | O Monthly or less | | O 4-5 x week | | | |
| | | O 2-3 x month | | O 6-7 x week | | | |
| | How many drinks containing alcohol do you have on a 'typical day' when drinking | O 1-2 drinks | | O 7-8 drinks | | | |
| | | O 3-4 drinks | | O 10 or more drinks | | | |
| | | O 5-6 drinks | | | | | |
| | How often do you have 6 or more drinks on one occasion | O Never | | O Weekly | | | |
| | | O less than monthly | | O Daily or almost daily | | | |
| | | O Monthly | | | | | |
| **Other substance use** | Do you use any of the following substances? | O Cannabis | | O Cocaine | | | |
| | | O Methamphetamine | | O Other | | | |
| | Do you have concerns about substance abuse | | | | Yes | | No |

## Social Situation

| | | | | | |
|---|---|---|---|---|---|
| **Living Situation** | What is your living situation today | O I have a steady place to live | | | |
| | | O I have a place to live today , but I am worried about losing it in the future | | | |
| | | O I do not have a steady place to live (temporary accommodation with others/motel/hotel/car/street) | | | |
| | Do you have concerns about the following problems in your current living situation? (**select all that apply)** | O Pests | O Water leaks | | |
| | | O Mould | O none of the above | | |
| | | O Lack of heat | O Other | | |
| | | If Other, please state: | | | |
| **Food Availability** | In the past 12 months have you worried that your food might run out before you had money to buy more? | O Never | | | |
| | | O Sometimes | | | |
| | | O Often | | | |
| **Transportation** | Do you have a current Drivers licence? | | Yes | | No |
| | In the past 12 months has lack of reliable transportation kept you from medical appointments, meetings, work or getting things needed for daily living? | | Yes | | No |

| | |
|---|---|
| **Signed** | |
| **Date** | |