Churton Park Medical Care

SMOKING STATUS

FOR ALL PATIENTS 15 YEARS OF AGE AND OVER

Name: **DOB:**

Smoking status: Do you smoke? Please tick as appropriate:

- No never
- Yes - how many per day?______________Number of years_____________________
- Would you like help in quitting? please circle YES / NO
- Past/ex-smoker - quit over 12 months ago
- Past/ex-smoker - quit within the last 12 months

Do you vape? Please circle as appropriate: YES / NO

- Would you like help in quitting? please circle YES / NO

BREAST SCREENING CONSENT FOR FEMALES OVER 45 YEARS

FEMALE PATIENTS 45 years and over: consent for Mammogram results from Breast Screening Aotearoa

I___________________________________ DOB:__________give permission for Breast Screening Aotearoa to release my breast screening information to Dr ....

at Churton Park Medical Care.

Signed: Date: