TE KUNENGA KI PŪREHUROA MASSEY UNIVERSITY UNIVERSITY OF NEW ZEALAND

CONFIDENTIAL

Massey University Health & Counselling Centre - Auckland

2025 PATIENT REGISTRATION FORM

V C N

If you are a **NZ student who wishes to stay enrolled with your own GP** and use Massey Student Health as a casual patient, or you are an **International Student**, please complete the details below & return to Student Health Reception or email to: studenthealth.auckland@massey.ac.nz

Note: This form is only valid for the current academic year.

(Where there is a choice of answers tick (✓) those which apply to you).

PERSONAL DETAILS **Student ID Number:** .....

First Name (in full): ..... **Surname:** .....

Other Names (ie Maiden Name):..... Preferred or English Name: .....

NZ Address: .....

.....

Date of Birth (dd/mm/yyyy): ..... **NZ Mobile:** .....

☐ *Please tick if you **DO NOT** give permission for the Health & Counselling Centre to text your mobile phone*

Sex at birth: Male ☐ Female ☐ **Gender Identity**: ..... **Pronouns:** .....

Email: ..... NHI Number *(if known):* .....

NZ Emergency Contact/Next of Kin: Name: ..... Relationship ..... Phone: .....

New Zealand Citizen / Permanent Resident: Yes ☐ No ☐

Ethnicity: *(tick which apply)*

☐ NZ European	☐ Māori *(please state iwi)*		☐ Samoan
☐ Fijian	☐ Cook Island Māori	☐ Tongan	☐ Niuean
☐ African	☐ Chinese	☐ South East Asian	☐ Indian
☐ Middle Eastern	☐ European	☐ Other *(please state)*.....	

Do you need an interpreter: Yes ☐ No ☐

Course:

☐ Internal Student	☐ Distance Student	☐ Undergraduate	☐ Postgraduate

☐ Humanities & Social Sciences	☐ Design/Fine Arts/Music	☐ Health
☐ Business / Aviation	☐ Engineering	☐ ESOL (English Language School)
☐ Education	☐ Science	☐ PACE

Consent for the collection, use & release of information:

☐ I consent to Massey Student Health & Counselling requesting a copy of my medical history from my current GP to ensure ongoing continuity of care.

- PMS Front Page (including regular medications & dose); Medicine allergies; Immunisation history

I authorise the collection, use and release of any information about me to the extent that is needed to assess and manage my health care. I understand that this authority relates to all aspects of my health care including screening, recall activities and counselling, while under the care of the Health & Counselling Centre including external and internal agencies such as the Ministry of Health, hospitals, specialists, ACC, PHO and other medical and mental healthcare providers.

I understand that Massey University Health & Counselling Centre will at all times comply with the guidelines of the Privacy Act 2020 and Health Information Privacy Code 2020.

I understand that this practice is entitled to charge a fee for the health and counselling services it provides and that I agree to pay such costs according to the policy of the practice including any additional costs associated with the collection of overdue or unpaid accounts. In the event of an ACC claim being declined I agree to pay the balance of the fee owing.

Signature: ..... Date:.....

Please turn over & complete Medical History

MEDICAL HISTORY

REGULAR DOCTOR:

NZ Students: Who is your regular doctor *(GP Name, Practice Name, Town/City)*: .....

..... Telephone: .....

International Students: Have you seen another Doctor or Medical Centre since you have been in New Zealand?

No ☐ Yes ☐ If Yes, where were you treated? .....

PERSONAL HISTORY: *Please tick & enter details of any disease you have had in the past, or have now:*

☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Migraine

☐ Psychiatric Condition (eg depression/anxiety) ☐ Cardiac Condition (eg murmur, hypertension) ☐ Other disease (eg hepatitis) ☐ Other

If you have ticked any of the above, or had any operations, please provide additional details:.....

.....

Allergies: Are you allergic to any medicines, tablets, injections or anything else eg bees?

No ☐ Yes ☐ If Yes, please enter details?.....

ALLERGIES	DETAILS/REACTION TO MEDICATION
Drug Allergy	
Other Allergy	

Do you have a disability? No ☐ Yes ☐ If Yes, please provide brief details? .....

.....

Medication

List all the medications you are taking including any supplements and medicine bought from a Pharmacy

.....

Alcohol: How many alcoholic drinks do you have in a week: ☐ None ☐ 1-10 ☐ 11-20 ☐ >20

Smoking Status: No Never Smoked ☐ Ex-Smoker ☐ Date quit: .....

Current Smoker ☐ Approx. ..... smoked per day

If Current Smoker:

The best advice we can give you for your health and well-being is to quit smoking. Here at the Massey University Health Centre we can help you on your journey to wellness. Please tick if you would like to be contacted for support to quit smoking.

☐ Yes, to be contacted

☐ No, no contact at this time (you may be asked again in the future)

Family History: Has any blood relative had any of these diseases? *(Please state relative eg father and give details)*

DISEASE	RELATIVE	DETAILS	DISEASE	RELATIVE	DETAILS
Asthma			Epilepsy		
Diabetes			Psychiatric Condition		
High Blood Pressure			Blood clots		
Heart Attack			Migraine		
Stroke			Other		
Cancer					

Write any further details here .....