

New Patient Medical Information Form

Patient Name: _____ **DOB** _____

ALLERGIES Nil Known

ALLERGY / INTOLERANCE	REACTION	SEVERITY

CURRENT MEDICATIONS including vitamins and mineral supplements

DRUG / STRENGTH	DOSE / DAY	DRUG / STRENGTH	DOSE / DAY

MEDICAL HISTORY – Do you have / have you had a history of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stomach or duodenal ulcer | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cancer – type: _____ | | |

Other illness/surgery – please give details _____

LIFESTYLE HEALTH HISTORY (specify approximate month/year)

Smoking history

- Never smoked
- Former smoker, quit date _____ / _____
- Current smoker _____ /day

Alcohol Intake -

- Do you drink alcohol? yes no
- Drinks per day _____
- Days per week _____

Number of years smoking _____

(Please turn over and complete page 2)

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IMMUNISATIONS

- Pneumococcal (pneumonia) Influenza Tetanus
 Childhood vaccines up to date
 Other (please specify) _____

FAMILY HISTORY

	QUESTION	YES	NO
1.	Have any of your close relatives had heart disease before 60 years of age? <i>Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery.</i>		
2.	Have any of your close relatives had diabetes? <i>Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes.</i>		
3.	Do you have any close relatives who had melanoma?		
4.	Have any of your close relatives had bowel cancer before 55 years of age?		
5.	Do you have more than one relative on the same side of the family who had bowel cancer at any age? <i>Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.</i>		
6.	Have any of your close male relatives had prostate cancer before 60 years of age?		
7.	Have any of your close female relatives had ovarian cancer?		
8.	Have any of your close relatives had breast cancer before 50 years of age?		
9.	Do you have more than one relative on the same side of your family who has had breast cancer at any age? <i>Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.*</i>		
10.	Is there a history of mood disorder in your immediate family?		

Other information _____

Patient Signature _____ **Date** _____