



MEDICAL HISTORY – NEW PATIENTS

Your health history – do you have or have you had a history of?

- Operations _____
- Asthma _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Mental Illness _____
- Cancer _____
- Muscular/skeletal (arthritis/muscle/joint pain) _____
- Other _____

Current medications (including over the counter medications, vitamins and minerals):

Social History

- Tobacco _____ day/week or cease smoking – date _____
- Alcohol _____ day / week / month (circle the one applicable)
- Drug use _____ (type and frequency)

Do you have any allergies or are you sensitive to drugs or dressings:

- Yes No
- _____
- _____

Blood Pressure: when was the last time your blood pressure was taken?

For those 65 years and older: when was the last time you were immunised?

- Influenza Date _____ not sure never
- Pneumococcal pneumonia Date _____ not sure never

Females: when did you last have?

- Pap smear Date _____ not sure never
- Breast check Date _____ not sure never

Males: when did you last have?

- An overall check-up Date _____ not sure never