MEDICAL HISTORY FORM – NEWLY ENROLLING PATIENT

Name: _____Date of Birth: _____

Do you have any Medication Allergies?

- ☐ NO
- ☐ YES please list and describe the reaction: _____

Alcohol Consumption:

- ☐ Non drinker
- ☐ No more than 10-15 standard drinks per week. At least two alcohol free days per week
  Not binge drinking ie 5 or more drinks on one occasion
- ☐ More than above guideline

Do you have any hearing or visual difficulties that we should be aware of prior to your consultation?

NO/YES _____

Medications: including over the counter, herbal supplements and recreational drug use.

NAME:	DOSE:	TIMES PER DAY:

Medical History: Current and Past medical problems.

Prolonged or repeated hospital admission and or surgery for any reason. ☐ YES / NO	If YES please provide details and approximate dates.
Heart Conditions: ie ☐ High blood pressure ☐ High cholesterol ☐ Previous heart attack or surgery ie stents ☐ Irregular Rhythm ie AF ☐ Angina ☐ Other	If YES please provide detail ie current / past. Have you have you have blood tests and or a cardiac risk assessment in the last year?
Respiratory Conditions: ☐ Asthma ☐ COPD ☐ Other	If YES have you had a review of this condition in the last year?
Diabetes / Endocrine: ☐ Type 1 diabetes ☐ Type 2 diabetes ☐ Other / Unsure	If YES have you have a diabetic review in the last year? Ie bloods, eye test and feet review
Abdominal conditions: ie ☐ Reflux (GERD) ☐ Gall stones ☐ Celiacs disease	If YES please provide estimated date of diagnosis and current management.

☐ Inflammatory bowel disease (Chronis or Ulcerative Colitis) ☐ Diverticulosis ☐ Hepatitis ☐ Other	
Urinary / Urology: ie ☐ Kidney stones ☐ Enlarged prostate / Prostate cancer ☐ Other	If YES please provide estimated date of diagnosis and current management.
Mental Health conditions: ie ☐ Anxiety ☐ Depression ☐ Austism Spectrum Disorder (ASD) ☐ Bipolar / Psychosis / PTSD ☐ Substance use and or addiction	If YES are you currently under any other mental health service providers? _____ Would you be interested in speaking to our Health Improvement Practitioner regarding your current mental health? YES / NO
Cancer or malignancy ie ☐ Melanoma ☐ Bowel cancer ☐ Brest cancer ☐ Lung / Prostate	If YES, please provide date of diagnosis.
Woman's Health: ☐ Are you pregnant? ☐ Are you aged between 25-69 years? ☐ Are you aged between 45-69?	If YES: Estimated date of delivery: _____ Are you up to date with your cervical screening? YES / NO / Unsure Are you up to date with your mammogram?
Any other medical conditions? ☐ YES ☐ NO	If YES please provide details:

Family History (specific interest in Cancers and or Cardiac Conditions)

Relationship	**Significant Medical History**	Alive or Deceased	Cause of death if known
Mother		Alive / Deceased	
Father		Alive / Deceased	
Siblings - Ages		Alive / Deceased	
Children		Alive / Deceased	

Social History:

- Who do you live with_____
- Have you had any previous exposure to harmful substances at work or home in the past? YES / NO
- Do you currently hold a gun license? YES / NO
- Do you have any specific religious beliefs we should be aware of? ie use of blood products. NO / YES
- Is there anything we have missed that you would like us to document in your records?