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

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

☐ Heart Disease ☐ High Blood Pressure ☐ High cholesterol

☐ Diabetes ☐ Migraine ☐ Mental Illness

☐ Stroke ☐ Blood clots ☐ Asthma

☐ Stomach or duodenal ulcer ☐ Depression / Anxiety ☐ Epilepsy

☐ 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

Number of years smoking _____

Alcohol Intake -

Do you drink alcohol? ☐ yes ☐ no

Drinks per day _____

Days per week _____

(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?** *Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery.*		
2.	**Have any of your close relatives had diabetes?** *Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes.*		
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?** *Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.*		
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?** *Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.**		
10.	**Is there a history of mood disorder in your immediate family?**		

Other information _____

_____

_____

_____

Patient Signature _____ **Date** _____