Patient Medical History Form

Given Names: ________________________________ Surname: ________________________________

Date of Birth: ________________________________ Date: ________________________________

In order to assist us to provide excellent care for you please fill out this questionnaire. All information you provide will be kept confidential.

Medical History:

Do you have any known allergies (i.e. medications or foods)? ☐ Yes ☐ No
If yes, please list them and describe the reaction:

Allergy	Reaction

Please list your current medications, including over the counter medications, vitamins and herbs. ☐ I do not take any medications
Please provide dosage information where possible:

Medication	Dosage	Medication	Dosage
1.		4.	
2.		5.	
3.		6.	

Please list any medical problems, past medical history or hospitalisations (i.e. asthma, diabetes, heart disease):

____

Please list any past surgeries/operations:

____

Social History:

Occupation: ____________________________
Marital Status: Single ☐ De facto ☐ Married ☐ Divorced ☐ Widowed ☐
Hobbies/sports/interests: ____

Have you ever regularly used tobacco (smoke cigarettes, pipe, chew tobacco)? ☐ Y ☐ N
If yes, are you a:
☐ Current smoker How many cigarettes/how much tobacco per day?________ How many years?_________
☐ Ex-smoker What year did you quit smoking?_____________

Alcohol (please circle one for each question)
How many days per week do you usually drink alcohol? 0 1 2 3 4 5 6 7
How many standard drinks (circle one) per session would you consume? 0 1 2 3 4 5 6 +
In the last 12 months, have you used marijuana, ecstasy, methamphetamine, cocaine, or abused prescription medication, or any other drugs? ☐ Y ☐ N
Are you sexually active? ☐ Y ☐ N
If yes:
Do you ever have sex without a condom? ☐ Y ☐ N
Do you have sex with: ☐ Men ☐ Women ☐ Both

Family Medical History:

Is your Father still alive? ☐ Y ☐ N Is your Mother still alive? ☐ Y ☐ N

Did/Does you father have any of these conditions? (Please tick all that apply)

High Cholesterol ☐ Bowel Cancer ☐ Melanoma ☐ Stroke ☐
Heart Disease ☐ Diabetes ☐ Prostate Cancer ☐ High Blood Pressure ☐

Other: ____

Did/Does your mother have any of these conditions? (Please tick all that apply)

High Cholesterol ☐ Bowel Cancer ☐ Breast Cancer ☐ Melanoma ☐ Stroke ☐
Heart Disease ☐ Diabetes ☐ High Blood Pressure ☐

Other: ____

Health-Related Behaviours:

Are you comfortable with your weight?	❐ Y	❐ N
Do you have healthy eating habits? (i.e. low fat and less fast food consumption)	❐ Y	❐ N
Do you exercise at least 3 times a week? (a minimum of 30 minutes per session)	❐ Y	❐ N
Do use sunscreen to protect your skin from the sun?	❐ Y	❐ N

What year was your last:

Pap Smear (women) __________________________ Pap result: Normal / Abnormal (please circle one)

Blood Tests __________________________

Do you have concerns about your partner abusing you by hitting, yelling or putting you down?
- If you are concerned, please know that we can help and provide you with resources and support -