New Patient Medical Information

Name: …….

Occupation: ……

Known Allergies: ……

Your Medical History:

Do you, or have you had, any of the following	Yes	No	Details
Heart Disease			
High Blood Pressure			
Stroke or Haemorrhage			
Blood Clots			
High Cholesterol			
Diabetes or elevated blood sugar			
Kidney, Urinary or Bladder Disorders			
Stomach or Bowel Problems			
Liver Disorders including Hepatitis			
Any cancer or tumour including skin cancers			
Eczema, Psoriasis, Dermatitis or other skin disorders			
Asthma, Bronchitis or Respiratory Disorders			
Migraines			
Back or Spinal Problems or Joint Conditions			
Depression, Anxiety or Stress			
Epilepsy			

WOMEN ONLY – please complete the following section

Do you, or have you had any of the following?	Yes	No	Details
Ever been pregnant			
Complications with pregnancy & childbirth			
Problems related to menstruation or menopause			
Abnormal Pap Test, Cervical Screening			
Abnormal Mammogram			

When was your last Pap Test/ Cervical Screening? …….

When was you last Mammogram? ……

Smoking History: **(Please circle relevant response)**

Never Smoked Current Smoker Ex Smoker : Year quit smoking : ……

Alcohol Consumption:

Do you drink alcohol? Yes/No

How often do you drink alcohol?

Never Less than monthly Monthly Weekly Daily or most days

Family Medical History

Does anyone in your family, (parents, grand parents, brothers, sisters, uncle, aunt, nieces or nephew) suffers or has suffered from:

Condition	Yes	No	
Heart Disease/Stroke			
Diabetes			
Cancer			
Any other medical condition			