New Patient Medical History Form

Name: _____ DOB: _____

Please complete the following health related information to assist your doctor in providing you the best possible care. The nurse will meet with you shortly to check your weight/height/blood pressure and help with any questions you are not sure about. We understand some of these questions are personal but they can have direct impact on your health and wellbeing and will help your doctor in caring for your health.

Allergies:

☐ Nil known allergies

☐ Allergic to: _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Life Style Factors:

Regarding your current alcohol intake:

☐ Non drinker ☐ Drinker

Approx Days per week that you have a drink: _____

Approx standard drinks per drinking day: _____

Regarding your past alcohol intake:

☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Regarding your current smoking history:

☐ Non-smoker ☐ Ex-Smoker Year Quit: ____ ☐Smoker Cigarettes per day: _____

Regarding your past smoking history:

☐ Light ☐ Moderate ☐ Heavy ☐ Never smoked

Year started _____ Year finished _____

Medical History:

Past Medical History:

_____

_____

_____

_____

_____

Past Surgical History:

_____

_____

_____

_____

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Family Medical History

☐ Unknown (eg adopted) ☐ No significant family history

Mother alive? ☐ Yes ☐ No Age of death_____ Cause of death_____
Father alive? ☐ Yes ☐ No Age of death_____ Cause of death_____

Significant family medical history:

Mother: ☐ Heart Disease ☐ Breast cancer ☐ Stroke ☐ Diabetes
☐ Bowel Cancer ☐ Hypertension ☐ Depression
☐ Other_____

Father : ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Diabetes
☐ Bowel Cancer ☐ Depression ☐ Other _____

Occupation: _____

Marital status:

☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Widowed ☐ Divorced

Sexuality:

We understand this question is personal but the answer to these questions can significantly affect your health and wellbeing. This information will help your doctor give you the best possible care.

What is your sex?
☐ Male ☐ Female ☐ Other (Indeterminate, Intersex, Unspecified) ☐ Prefer not to answer

What is your gender identity?
☐ Male ☐ Female ☐ Other (Indeterminate, Intersex, Unspecified) ☐ Prefer not to answer

What is your sexual orientation?
☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Prefer not to answer

Patient signature:_____ ***Date:***_____

Nurse examination findings:

Weight:_____ ***Height:***_____ ***Blood Pressure:***_____

OFFICE PURPOSES ONLY: Entered by:_____ Date: _____

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