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: (Must be completed)

☐ Nil known allergies
☐ Allergic to: (please tick reaction type below)

Name	Reaction Type	Mild	Moderate	Severe

Life Style Factors:

Regarding your current alcohol intake:
☐ Non drinker Approx Days per week that you have a drink: _____
☐ Drinker 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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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

Elite Athlete: ☐ Yes ☐ No

Advance Health Directive: ☐ Yes ☐ No Enduring Guardian: ☐ Yes ☐ No

Accommodation: ☐ Own Home ☐ Relatives Home ☐ Nursing Home ☐ Homeless ☐ Rental Home

Do you have a carer: ☐ Yes ☐ No If yes name of carer: _____

Do you feel safe in your own home: ☐ Yes ☐ No

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

Nurse examination findings:

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

OFFICE PURPOSES ONLY: Entered by:_____ Date: _____

New Patient Medical History Form

Your family's health can affect you…

The medical conditions of your close relatives may be relevant to your own health, especially if many of your relatives are affected by the same condition or a relative developed a condition early in their life. By filling out the following family history, your doctor can give you specific recommendations about your situation.

When considering your answers for this section, please refer to your genetic (blood) relatives (living or dead), including: your mother, father, children, brothers, sisters, grandparents, aunts and uncles.

Have any of the above mentioned relatives had:

- **Heart disease (heart attacks, angina, heart bypass surgery) or stroke?** Please list which relative(s) and the age they first were diagnosed:
  _____
  _____
  _____

- **Type Two Diabetes?** Please list which relative(s):
  _____
  _____
  _____

- **Melanoma?** Please list which relative(s) and the age they first were diagnosed:
  _____
  _____
  _____

- **Bowel cancer?** Please list which relative(s) and the age they first were diagnosed:
  _____
  _____
  _____

- **Prostate cancer?** Please list which relative(s) and the age they first were diagnosed:
  _____
  _____
  _____

- **Ovarian cancer?** Please list which relative(s):

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_____
_____
_____

- **Breast cancer?** Please list which relative(s) and the age they first were diagnosed:

_____
_____
_____

- **Glaucoma?** Please list which relative(s) and the age they first were diagnosed:

_____
_____
_____

- **Dementia?** Please list which relative(s) and the age they first were diagnosed:

_____
_____
_____

- **Kidney disease?** Please list which relative(s) and the age they first were diagnosed:

_____
_____
_____

Are there any other medical conditions that run in your family?

- Please list the condition(s) and which relative(s) are affected:

_____
_____
_____
_____
_____

Thank you for completing your family's health history.