CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Once completed please hand this multi-page questionnaire to reception. If there are any sections you prefer not to answer, feel free to leave them blank.

Patient Name …….. Age ……..

What medical concerns do you wish to discuss with your doctor today?

……
……
……
……

Which of these is most important?

……

What outcome would you like to achieve by the end of your consultation today?

……
……

Past Medical History

Have you suffered from any of the following – currently or previously?

Please circle

Heart Attack	Anxiety or Depression	Liver disease
Stroke	Glandular Fever	Kidney disease
Blood Clot	Asthma	Osteoporosis
High Blood Pressure	Diabetes	Fracture
Head Injury	Eye Problems	Hearing Loss
Epilepsy	Chickenpox	Cancer

Please list current and past serious illnesses, operations hospital admissions (if none write nil)

Year	Details

Preventative Health

General

When was your last screening for bowel cancer? …… Result ……

When were you last checked for skin cancer? ……..

Has your weight changed by more than 5 kg within the past 3 months? YES / NO

Have you had screening for Glaucoma? …….. By Whom ……

For Female patients

When was your last pap smear? ……

Have you ever had an abnormal pap smear – if yes please give details

……

When was your last mammogram? …… Result ……

When was your last bone density scan? …… Result ……

For Male Patients

When was your last screening for prostate cancer? …… Result ……

When was your last testicular check? ……

Immunisations

Have you received immunization against the following diseases? Please indicate year received.

Rubella		Flu		Polio	
Chicken Pox		HPV Virus		Hep B	
Tetanus		Meningococcal		Hep A	
Typhoid		Yellow Fever		Rabies	

Would you like a flu vaccine today? YES / NO

Current Medications

Please include **ALL** tablets, inhalers, patches, gels or injections – as well as any other natural remedies or supplements.

Name of Medication — Dose (if known) and frequency taken

……..

……

……

Allergies

Do you have any allergies? Or any food intolerances? YES / NO

Allergy Medication or Substance Reaction/Symptoms

…… ……..

…… ……..

Family History

Has anyone in your immediate family suffered from the following? Please Tick in the appropriate box.

Heart Attack		Bowel Cancer	
High Blood Pressure		Any other cancer	
Stroke		Arthritis	
Blood Clots		Depression	
Diabetes		Mental Illness	
Thyroid Disease		Haemachromatosis	
Osteoporosis		Other	
Breast Cancer		Other	

Social History

Occupation …… Marital Status ……

Life Style	***Number/per Day***	***Number in Past***	***Quit Date***
Smoker	……	……	……
Alcohol	……	……	……
Other Drug Us***e***	***……***	***……..***	***……***

Recreational

Exercise What Type ……

Duration/Frequency……

Diet Do you follow a particular diet? YES / NO

Please specify ……

Is there any other medical information you would like your doctor to know

……

……..

The information I have provided in this questionnaire is correct to the best of my knowledge.

Patient Signature ……. ***Date*** ……..