Hargreaves St
MEDICAL PRACTICE

MEDICAL HISTORY – NEW PATIENTS

Your health history – do you have or have you had a history of?

☐ Operations ______________________________
☐ Asthma ______________________________
☐ Diabetes ______________________________
☐ Heart Disease ______________________________
☐ High Blood Pressure ______________________________
☐ Mental Illness ______________________________
☐ Cancer ______________________________
☐ Muscular/skeletal (arthritis/muscle/joint pain)

____
☐ Other ______________________________

Current medications (including over the counter medications, vitamins and minerals):

____
____
____

Social History

☐ Tobacco ________ day/week or cease smoking – date ________
☐ Alcohol ________ day / week / month (circle the one applicable)
☐ Drug use ______________________________ (type and frequency)

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes ☐ No

____
____

Blood Pressure: when was the last time your blood pressure was taken?

____

For those 65 years and older: when was the last time you were immunised?

Influenza	Date_______	☐ not sure	☐ never
Pneumococcal pneumonia	Date_______	☐ not sure	☐ never

Females: when did you last have?

Pap smear	Date_______	☐ not sure	☐ never
Breast check	Date_______	☐ not sure	☐ never

Males: when did you last have?

An overall check-up Date_______ ☐ not sure ☐ never