Patient Clinical, Social & Family History

This clinic is dedicated to continually improving our quality of care and enhancing the health outcomes for our patients. By providing your past medical history, family history, and current social/lifestyle information, we can better provide you with the best quality holistic care.

Demographic

First Name		Surname	
Date of Birth		Date	

Allergy Information

Do you have any Allergies YES ☐ (provide details below including reaction) ☐ I have NO Known Allergies

Your Current Health

Do you have any of the Following Conditions?	Past Operations?
☐ Asthma ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Mental Health Concerns	
For Females: - Pap Smear Date:___________ ☐ Not sure ☐ never Breast Check Date:___________ ☐ Not sure ☐ never	**For Males**: - When did you last have an overall check-up? Date:___________ ☐ Not sure ☐ never
Current Medications *as well as* any complimentary medications you are taking…	
Any other medical information you would like to share?	

Family History

☐ No Significant Family History ☐ Unknown (e.g. Adopted)

It is important for your doctor know about any of the following :	
MOTHER Alive? ☐ YES ☐ NO Cause of Death: ____________________ Significant Family History :- ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Breast Cancer ☐ Depression	**FATHER** Alive? ☐ YES ☐ NO Cause of Death: ____________________ Significant Family History :- ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Breast Cancer ☐ Depression
Any other Family Member with Significant Medical Conditions? (Please state relationship & condition)	

Please Turn Over

Immunisation History

CHILD	ADULT
If completing this for a child, are their immunisations up to date? ☐ YES ☐ NO	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 *Shingles Vaccine Date:______________ ☐ Not sure ☐ never Other Vaccinations?

Social & Lifestyle Factors

CURRENT ALCOHOL INTAKE	CURRENT SMOKING HISTORY
☐ Non-Drinker or Days per week ______ Standard Drinks per day ______ How often would you have 6 or more drinks in any one occasion? ☐ Never ☐ Monthly ☐ Weekly ☐ Daily	☐ Non Smoker ☐ Ex -Smoker ☐ Smoker Year Started__________Year Stopped ____________ How many cigarettes per day? ____________
Do you live alone? ☐ Yes ☐ No	**Marital Status:**
Elite Athlete ☐ Yes ☐ No	**Occupation:**
Do you have a Disability?	**If yes, do you have a Carer?**

PLEASE TAKE THIS FORM WITH YOU TO GIVE TO YOUR DOCTOR