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 ☐ NO, I have **NO** Known Allergies	
Name of Allergen	**Reaction (e.g. rash, vomiting, hives, anaphylaxis, swelling, diarrhea,)**

Your Health

Do you have any medical conditions or Do you take any medicines for anything?

☐ Asthma ☐ High Blood Pressure

☐ Diabetes ☐ Heart Disease e.g. Heart Attacks, Heart Surgery

☐ Cancers (give details) _____

☐ Depression ☐ Anxiety

☐ Other Mental Illness (give details) _____

☐ Any other health Conditions (give details) _____

Past Operations/Surgery?

What Medications do you take (include ANY complimentary medications you are taking)

For Females: -

Last Pap Smear Date:_____ ☐ Not sure ☐ never

Last Mammogram/ Breast Ultrasound Date:_____ ☐ Not sure ☐ never

For Males: -

Last Prostate Check Date_____

☐ Not sure ☐ Never

Any other medical information you would like to share?

Immunisation History

CHILD	**ADULT**
If completing this for a child, are their immunisations up to date? ☐ YES ☐ NO	Have you ever had? *Flu Vaccine Date:_____ ☐ Not sure ☐ never *Pneumococcal Pneumonia Date:_____ ☐ Not sure ☐ never *Shingles Vaccine Date:_____ ☐ Not sure ☐ never *Whooping cough Date:_____ ☐ Not sure ☐ never *Tetanus Vaccine Date:_____ ☐ Not sure ☐ never *Any Other Vaccinations (include dates)? _____

Please Turn Page Over →

Family History

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

MOTHER	**FATHER**
Alive? ☐ YES ☐NO Cause of Death: _____Age:_____	Alive? ☐ YES ☐NO Cause of Death: _____Age:_____
What medical conditions did your **Mother** have?	What medical conditions did your **Father** have?
☐ Diabetes ☐Hypertension ☐Heart Disease ☐Stroke	☐ Diabetes ☐Hypertension ☐Heart Disease ☐Stroke
☐Colon Cancer ☐ Breast Cancer ☐Depression	☐Colon Cancer ☐ Breast Cancer ☐Depression
☐Skin Cancer (type if known) _____	☐Skin Cancer (type if known) _____
☐Other) _____	☐Other) _____
Did your **mother** take any tablets for anything else?	Did your **father** take any tablets for anything else?
☐ YES (give details)	☐ YES (give details)

Any other Family Members with Medical Conditions? (Please state relationship & condition)
Include Aunts, Uncles, Grandparents, Siblings, Children

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	Do you **OR** have you ever smoked **EVER** in your life? ☐ YES ☐NO ☐ Non Smoker ☐ Ex-Smoker ☐ Smoker ☐Social Smoker *give details*_____ 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?	**Do you have a Carer? If yes, who?**

PLEASE TAKE THIS FORM WITH YOU TO GIVE TO YOUR DOCTOR