CONFIDENTIAL MEDICAL HISTORY QUESTIONAIRE

Seen By **doctor** _____
Scanned □

Once completed please hand this to your doctor

Patient name: _____ Date of Birth: _____

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

Past Medical History Have you suffered from any of the following – currently or previously, **what year**?

□ Heart Problems	□ Stroke	□High blood pressure	□ Blood clots	□ Glaucoma
□ Epilepsy	□ Anxiety/Depression	□ Asthma	□ Bronchitis	□ Diabetes
□ Back Pain	□ Eye Problems	□ Thyroid Problems	□ Hep C	□ Hep B
□ Liver Disease	□ Kidney disease	□ Osteoporosis	□ Fractures	□High Cholesterol
□ HIV	□ Any other? _____			

Preventative Health: Please tick the boxes where appropriate

ALL	**FEMALES**	**MALES**	**Any Illnesses, operations or hospital admission?**
Bowel Screening □ Date:	Pap smear □ Date:	Prostate check □ Date:	
Skin Check □ Date:	Mammogram □ Date:	Testis check □ Date:	
Unintended weight change □ _____ since____		Health check □ Date:	
	Immunisations:	Immunisations:	

Medications and Social History:

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

MEDICATION	**DOSE**	**FREQUENCY**	**SMOKER □ _____per day STARTED_____** **NON SMOKER □ EX-SMOKER □ QUIT IN _____**
			ALCOHOL _____ days per week _____ drinks per day
			NON-DRINKER □
			RECREATIONAL DRUGS □ Specify _____

FAMILY HISTORY	**MOTHER** Alive (Yes / No)	**FATHER** Alive (Yes / No)	**SIBLINGS**
Heart Attack	□	□	□
Bowel Cancer	□	□	□
Breast Cancer	□	□	□
High blood pressure	□	□	□
High Cholesterol	□	□	□
Stroke	□	□	□
Arthritis - Osteoarthritis/Rheumatoid?		□	□
Diabetes	□	□	□
Thyroid Disease	□	□	□
Haemochromatosis		□	□
Osteoporosis	□	□	□
Other:	□	□	□

ALLERGIES

_____
_____
_____
_____
_____

The Information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge.

Patient / Gauardian Signiture_____

Name: _____Surname:_____Date_____