Medical History

Cranbourne Park Family Care Clinic

Title: ***Full Name:*** _____ ***Date of Birth:*** …. / ….. / …….

Family History

Do you have a family history of any of the following? Family member (eg: Mother, father, sister, brother etc

❑	Bowel Cancer		Relative: ……..……....
❑	Breast Cancer		Relative: ……..
❑	Prostate Cancer		Relative: ……..……....
❑	Blood Pressure:	High / Low	Relative: ……..
❑	Cholesterol:	High / Low	Relative: ……..
❑	Diabetes:	Type 1 / Type 2	Relative: ……..
❑	Heart Disease:	Stroke / Heart attack	Relative: ……..
❑	Asthma		Relative: ……..
❑	Other: …….....		Relative: ……..

Current / Past Histories (operation / serious illness)

❑	Cancer:	Bowel / Prostate / Breast / Lung / Skin
❑	Cholesterol:	High / Low
❑	Diabetes:	Type 1 / Type 2
❑	Heart disease:	Stroke / Heart attack
❑	Osteoarthritis / Osteoporosis	
❑	Asthma	
❑	Previous Operations: ……	
❑	Other: ……..	

Allergies ***Reactions***

❑	No Known allergies	
❑	Penicillin:	Rash / Coughing / Sweats / Vomiting ……..…
❑	Codeine:	Rash / Coughing / Sweats / Vomiting ……...
❑	Other Medication: ……..….	Rash / Coughing / Sweats / Vomiting ……..
❑	Peanut:	Rash / Coughing / Sweats / Vomiting ……..…
❑	Other: ……..…	Rash / Coughing / Sweats / Vomiting …….....

Social History

Occupation: _____ **Retirement Date:** _____

Marital Status: *Single* ____ *Married* ____ *Separated* ____ *Divorced* ____ *Widowed* ____ *Other* _____

Does the patient have any children: Yes / No **How many:** _____

Is the patient an "Elite Athlete": Yes / No

Who does the patient live with: Spouse / Relative / Friend / Alone

Is the patient a carer for someone: Yes / No

Do you have a carer: Yes / No

Carer's name: _____ Carer's relationship to you: _____

Do you wish to idendify yourself as belonging to a specific religious group?

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SMOKING HISTORY

Non-smoker / Ex-smoker / Smoker

Cigarettes / Cigar / Pipe

Year Started: _____

Number per day: _____

Year stopped: _____

Please circle status below:

Not ready to quit / Ready to quit / attempted to quit

ALCOHOL HISTORY

Non Drinker / Occasional / Moderate / Heavy

Year Started: _____

Year Stopped: _____

Days per week: _____

Standard drinks per day: _____

Current Medications

Please list all your current regular medications (including non-prescription e.g. fish oil capsules)

NAME	DOSE	HOW OFTEN

Information entered into Patient's History

(SIGNED) **Dr.** _____

Date: ____ / ____ / _____