

DOCTORZ ON BENNETTS

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Once completed, please hand this multi-page questionnaire directly to you Doctor.
If there are any sections you prefer not to answer, feel free to leave them blank.

Patient name: _____ Age: _____

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

Which of these is most important?

What outcome would you like to achieve by the end of your consultation today?

Past Medical History

Have you suffered from any of the following – currently or previously?

Please circle:

- | | | |
|---------------------|-----------------------|----------------|
| Heart attack | Anxiety or depression | Liver disease |
| Stroke | Glandular fever | Kidney disease |
| Blood clot | Asthma | Osteoporosis |
| High blood pressure | Diabetes | Fracture |
| Head Injury | Eye problems | Hearing loss |
| Epilepsy | Chickenpox | Cancer |

Please list current and past serious illnesses, operations, hospital admissions (*if none write nil*)

Year	Details

Preventative health:

General:

When was your last screening for bowel cancer? _____ Result _____

When were you last checked for skin cancer? _____

Has your weight changed by more than 5kg within the past 3 months? YES / NO

Have you had screening for Glaucoma? _____ By Whom _____

For female patients:

When was your last pap smear taken? _____

If you have ever had an abnormal pap smear if yes please give details: _____

When was your last mammogram? _____ Result: _____

When was your last bone density scan? _____ Result: _____

For male patients:

When was your last screening for prostate cancer? _____ Result _____

When was you last testicular check? _____

Immunisations:

Have you received immunisation against the following diseases? Please indicate year received in box.

	Rubella		Flu		Polio
	Chicken pox		HPV virus		Hep B
	Tetanus		Meningococcal		Hep A
	Typhoid		Yellow Fever		Rabies

Current medications:

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

Name of Medication	Dose (if known) and frequency taken

Allergies:

Do you have any allergies? Or any food intolerances?

Allergy – medication or substance	Reaction/symptoms caused

Family history:

Has anyone in your immediate family suffered from the following? Please tick in appropriate box.

Disease	Relative affected and their age	Disease	Relative affected and their age
Heart attack		Bowel cancer	
High blood pressure		Any other cancer	
Stroke		Arthritis	
Blood clot/s		Depression	
Diabetes		Mental illness	
Thyroid disease		Haemachromatosis	
Osteoporosis		Other:	
Breast cancer		Other:	

Social History:

Occupation: _____ Marital Status: _____

Lifestyle

	Number/day	Number in past	Quit date
Smoker/Non smoker (circle)			
Alcohol			
Other drug use Type:			

Recreational

Exercise:

What type do you do? _____

Duration and frequency of exercise _____

Diet:

Do you follow a specific diet? YES / NO

If so, please specify _____

Is there any other medical information you would like your doctor to know also?

The information I have provided in this questionnaire is correct to the best of my knowledge.

Patient Signature _____

Date _____