



## Medical History: First Visit Form

### Patient information

Name & Surname	
Address	
Referred by	

<b>Date</b>	dd/mm/yyyy		
<b>Title</b>	Mr	Mrs	Ms
<b>Date of birth</b>	dd/mm/yyyy		
<b>Age &amp; Weight</b>	yrs	kg	
<b>Gender</b>	male	female	

**Welcome to our practice. Please complete this form with as much detail as possible.  
 The more information I have, the better we can help you. Nothing is unimportant. Thank you!**

1. Main concerns and existing conditions. Please indicate how long each has been a problem.

1.1	duration	1.5	duration
1.2	duration	1.6	duration
1.3	duration	1.7	duration
1.4	duration	1.8	duration

2. Previous surgery and age at time of surgery (incl. cosmetic, orthopaedic, dental, childhood, minor or post-trauma)

2.1	age	2.4	age
2.2	age	2.5	age
2.3	age	2.6	age

Have you ever been admitted to hospital for any reason other than surgery?  Y  N  
 If yes, please give details and doctors involved (includes Psychiatric or Rehab)


3. Current medication: Please specify dosage and duration.

3.1	dosage/duration	3.6	dosage/duration
3.2	dosage/duration	3.7	dosage/duration
3.3	dosage/duration	3.8	dosage/duration
3.4	dosage/duration	3.9	dosage/duration
3.5	dosage/duration	3.10	dosage/duration

### 4. Allergies

Reactions to medications


Environment or food allergies (eg. hayfever, metal sensitivity to jewellery, etc.)




## 5. Supplements

Do you use any supplements, homeopathic remedies and/or natural products? Please specify.


Discontinued or changed supplements or medications. Please specify why.


## 6. Dental history

Number of metal fillings and/or crowns		Have you had any removed?	
Any braces or retainers still present?		Do you use a bite plate or grind your teeth?	
Other dental issues, please specify			

## 7. Conditions

Have you ever been diagnosed with, or suspected of having, any of the following. Please mark with an "X."

Anxiety	Arthritis	Asthma	Cancer	Cardiac disease
Cholesterol	Chronic fatigue	Circulatory disorder	Depression	Diabetes
Excema	Epilepsy	Fibromyalgia	Gout	Hepatitis
HIV	Hypertension	Kidney stones	Malaria	Migraine
Renal disease	Spastic colon	Psoriasis	Thyroid	Tick bite fever
Gallstones	Headaches	Hayfever	Porphyria	Diverticulitis
Crohn's	Ulcerative colitis	Lung disease	COPD	Other
If other, please specify:				

## 8. Family history

Please list any medical problems and/or cause of death of the following family members.

Father	alive	deceased	age	
Mother	alive	deceased	age	
Sibling	alive	deceased	age	
Sibling	alive	deceased	age	
Sibling	alive	deceased	age	

## 9. Work

What do you currently do?			
Where have you worked in the past?			
How many hours a week do you work?		How many hours do you spend in traffic per week?	
Do you like what you do?			

## 10. Body composition: Please complete if known.

Current weight	kg	Best weight ever	kg	Desired weight	kg	Heaviest weight	kg
Height	m	Waist	cm	Hip	cm	Ratio Waist:Hip	
Weight gain or loss in last 5 years	Reason						

continued on next page

## 11. Habits and Diet

11.1 Smoker	Ex	Current	Never	How many per day?	How many years?	When last ?	
11.2 Alcohol	Type and rough estimate of amount per week						
	Previously drank more	Y	N	Why the change?			
11.3 Exercise	How do you feel after exercise?						
11.4 Social	Marital status		Kids at home		Previously divorced		Y N
11.5 Diet	Do you follow a specific type of diet programme? eg. Banting, Paleo, Weight Watchers, etc.						
11.6 Water	Daily intake		What else do you drink?				
	Please indicate how many of these you consume per day						
	Coffee	Tea	Sugars	Energy drinks (eg. Red Bull)	Type of sweetener		
11.7 Sleep	Quality						Number of hours
	Do you experience any of the following? Please mark with an "X".						
	Struggle to fall asleep	Must use sleeping tablet	Wake in early hours, can't sleep	Snore	Stop breathing		

## 12. Body systems: Do you experience any of the following? Please mark with an "X".

<b>Mood:</b>							
Happy	Anxious	Obsessive	Aggressive	Irritable	Depressed		
<b>Energy:</b>							
Permanent fatigue	Fluctuates	Afternoon dips	Morning tiredness	Dips a few hours after exercise	Plenty		
<b>Abdominal:</b>							
Cramping	Diarrhoea	Constipation	Heartburn	Ulcers	Hiatus hernia		
Previous colonoscopy	Previous gastroscopy	Previous surgery	Bloating	Feel full quickly	Burping		
<b>Heart:</b>							
Chest pain	Palpitations	Angina	Irregular heart rate	Previous angiogram	Previous cardiac surgery		
Heart failure	Fluid retention	Short of breath quickly	High blood pressure	Low blood pressure	Cholesterol medication		
<b>Lungs:</b>							
Short of breath	Cough	Asthma	Emphysema	Still smoking	Fingers go blue		
<b>Joints and muscles:</b>							
Aches and pains	Cramping	Stiffness	Weakness	Joint pain	Back pain		
<b>Nerves:</b>							
Weakness	Pins and needles	Burning feet	Shooting pains	Ataxia/Off-balance	Tremor		
<b>Bladder:</b>							
Incontinence	Leak if sneeze	Frequent infection	Get up at night	Urgency if need to go	Weak stream		
<b>Gynae:</b>							
Last visit to gynae	<sup>20</sup> Last pap smear	<sup>20</sup> Last mammogram	<sup>20</sup> Last sonar	<sup>20</sup> Cancer	Oestrogen sensitive		
<b>Immune system:</b>							
Get sick easily	Slow to heal or recover	Frequent antibiotics	Antihistamines	Cortisone	Chemotherapy		
<b>Hormones:</b>							
Fatigue	Feel hot	Always cold	Sweat a lot	Sweat too little	Morning tiredness		
Crave salt/sugar or chocolate	Afternoon energy dips	Poor sleep	Swelling in neck	Cold hands or feet	Poor circulation		
<b>Psychology:</b>							
Depression	Bipolar	Anxiety	Schizophrenia	Previous self-harm	Addiction history		
<b>Skin:</b>							
Dry	Oily	Scaly	Excema/Psoriasis	Allergy/Rashes	Abscesses/Acne		
<b>Eyes/Ears/Nose/Throat:</b>							
Spectacles	Contacts	Glaucoma	Dryness of eyes	Sinusitis/Post nasal drip	Dizziness		
Allergies	Vertigo/Dizziness	Polyps	Deafness	Lump in throat	Thyroid		
Other:							

**MALE PATIENTS ONLY**

Do you experience any of the following? Please mark with an "X".					
Problems with erection or sensation		Problems with ejaculation		Low libido	
How long have these been a problem?					
Do you experience any of the following? Please mark with an "X".					
Tendency to procrastinate		Increase in anxiety levels		Grumpy	
Snoring/Sleep apnoea		Fall asleep in front of TV		Fatigue	
Must run if bladder full		Urine pressure low / Have to wait for flow			

**FEMALE PATIENTS ONLY**

**13. Gynae history**

**13.1 Pregnancies**

Ectopic		Miscarriage		No. of living children		Children's ages	
Normal deliveries		Caesarians		Fertility treatment			
Difficulty falling pregnant	Y/N	Medical conditions during or after pregnancy					
Weight gain that couldn't be lost		Breastfed babies	Y/N				
Depression after pregnancy							

**13.2 Contraceptive**

Current		Sterilised	Y/N	Previous			
How did you respond to contraceptives?							
Used for:	Contraception	Y/N	Skin / Acne	Y/N	Period control	Y/N	Total years on contraceptive?

**13.3 Period history**

No. of bleeding days		Average length of cycle		Last normal period		
How are/were your periods <u>without</u> contraceptive? Please mark with an "X".						
Regular	Irregular	Heavy	Light	Short	Long	Painful

**13.4 Period symptoms**

Please rate symptoms before/during your period from 1 to 10 where 1 is "Mild" and 10 is "Severe."					
Headaches		Breast tenderness		Moody	
Swelling		Irritable		Fluid retention	
				Sugar cravings	

**13.5 Hormone therapy**

Hormone Replacement Therapy (HRT)	Y/N	If "yes", please specify HRT history				
Poly Cystic Ovarian Syndrome	Y/N	Endometriosis	Y/N	Hysterectomy	Y/N	Age at hysterectomy
Reason for hysterectomy						

**14. General symptoms: Rate from 1 to 10 where 1 is "Okay" and 10 is "Really bad."**

Hot flushes		Tiredness		Poor sleep		Low libido
Skin dry		Vaginal dryness		Hair loss/thinning		Moody
Poor memory		Unclear thinking		Vaginal thrush		Cellulite
Weight gain on tummy		Swelling/fluid retention		Bladder leaking		Sweating
Hair growth on face						

THANK YOU - I look forward to "Walking the path to better health, with you."

