ASHBURTON FAMILY PRACTICE

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Once completed please hand this to your doctor

Patient name: _____ DOB: _____

Past Medical History: Have you suffered from any of the following – currently or previously?

□ Heart Problems	□ Stroke	□ High Blood Pressure	□ Blood clots
□ Epilepsy	□ Anxiety/Depression	□ Breathing problems	□ Diabetes
□ Thyroid Problems	□ Bowel Problems	□ Cancers	□ Liver Disease
□ Kidney Problems	□ Fractures	□ High Cholesterol	□ HIV
		□ Hepatitis B/C	□ Skin Disease

□ **Any Other?**

Past Operations / Procedures:

Do You Have any Allergies? □ Yes □ No **Do You carry an epipen?** □ Yes □ No	**Please Specify:** Medication …… Food …… Other……

Preventative Health: Please tick & date the boxes where appropriate.

ALL	**FEMALES**	**MALES**	**Do You Drink?** □ Yes □ No How Much? Days per week - Amount -
□ Bowel Screening	□ Pap Smear	□ Prostate Check	
□ Skin Check	□ Mammogram	□ Testes Check	

Do you Smoke? □ Yes □ No	**No. of Cigarettes a day ……..**	**No. of years smoking ……..**
Ex-smoker? □ Yes □ No	**Year Stopped ……..**	
Do You take any Recreational Drugs?		

Medications: Include all tablets, inhalers, patches, gels, injections, and "natural" remedies/supplements.

Medication:				
Dose:				
Frequency:				

Family History: (Continue overleaf if more space required)

Are your parents alive? □ Yes □ No	**If so, which?** Father / Mother / Both

Does anyone in your family have a history of:

□ Heart Attack	□ Stroke	□ Bowel Cancer	□ Breast Cancer
□ High Blood Pressure	□ High Cholesterol	□ Arthritis	□ Diabetes
□ Haemochromatosis	□ Thyroid Disease	□ Osteoporosis	
□ Any Other?			

If yes who is affected?

Signature: Date: