health plus.

PATIENT HISTORY QUESTIONNAIRES

Admin Only:

Doctor: _____

☐ Scanned ☐ Data Entry

NAME: _____ DOB: _____ Today's Date: _____

Medical Conditions

Have you ever been treated for any of the following Medical Conditions?

- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Liver Problems
- ☐ Bladder Problems
- ☐ Anaemia
- ☐ Obstetric Problems
- ☐ Osteoporosis
- ☐ Anxiety/Depression
- ☐ Others (please specify):
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Kidney Problems
- ☐ Skin Conditions
- ☐ Bleeding Problems
- ☐ Gynaecological
- ☐ Sexual Health Issues
- ☐ Psychiatric Disorder
- ☐ Diabetes
- ☐ Seizure/Epilepsy
- ☐ Bowel Problems
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Ear, Nose, Throat
- ☐ HIV/AIDS
- ☐ Chronic Pain
- ☐ Heart Problems
- ☐ Cancers
- ☐ Thyroid Problems
- ☐ Autoimmune Disease
- ☐ Genetic/Congenital Diseases
- ☐ Eye Problems
- ☐ Hepatitis
- ☐ Drug/Alcohol Dependency

Medications

Please list your current medications. This includes prescriptions, drops, sprays, creams, over the counter medications, and vitamins. Please include their dosage and frequency if known.

Allergies

Please list any allergies you have to medications, food, latex, dyes, and include the adverse reaction it causes for you.

☐ I have no known allergies (NKA)

Recent Hospitalisation

Please list any recent hospitalisations. Include what you were hospitalised for, the dates of hospitalisation, and descriptions of any investigations and treatments you had.

Previous Surgery

Please list any surgeries you have had and include the date if known.

Family History

Please list any known medical issues within your family, including your children. List the issue and the person's relationship to you.

PLEASE CONTINUE TO NEXT PAGE ▶

Social & Lifestyle History

Alcohol Consumption:

How often do you drink alcohol? ☐ Never ☐ Rarely ☐ Socially ☐ Frequently

If frequently, how many times per week? ☐ 1-2 ☐ 3-5 ☐ More than 5

What do you normally drink? ☐ Beer ☐ Wine ☐ Spirits

On each occasion, how much do you normally drink? ☐ 1-5 ☐ 6-12 ☐ More than 12

1 drink = 1 can of beer, 1 glass of wine, or 1 shot of spirits

Cigarette Smoking:

☐ Smoker ☐ Ex-Smoker ☐ Non-Smoker (Please skip to next question)

When did you start smoking? Year: _____

On average, how many cigarettes do you smoke per day? Number: _____

If you are an ex-smoker, when did you quit? Year: _____

Drug Use:

Have you ever used recreational drugs? ☐ Yes ☐ No (Please skip to next question)

If yes, what drugs do you normally use? _____

If yes, how often do you use? ☐ Rarely ☐ Occasionally ☐ Frequently

Living Arrangements:

☐ On your own ☐ With a Spouse/Partner ☐ With Parents

☐ With other family or friends ☐ In Shared Accommodation ☐ With Children ☐ Other: _____

Exercise:

Do you engage in any form of regular physical activity (at least 3 days per week)? ☐ Yes ☐ No

Are you an elite athlete or performer? ☐ Yes ☐ No

Preventative Health

General:

When was your last screening for bowel cancer? Year: _____

When was your last skin cancer check? Year: _____

When was your last screening for cholesterol and diabetes? Year: _____

Immunisations:

Have you received the following immunisations? Please tick and include the year last received.

☐ Flu Vaccine: _____ ☐ HPV (Gardasil) _____ ☐ Tetanus/Diphtheria/Pertussis Vaccine _____

☐ Hepatitis B: _____ ☐ Shingles (Zostavax) _____ ☐ Pneumonia (Pneumovax) _____

Female Patients Only:

When was your last pap smear? Year: _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No If yes, when? Year: _____

When was your last mammogram? Year: _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No If yes, when? Year: _____

When was your last bone density scan? Year: _____

Are you currently: Pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

For Male Patients:

When was your last screening for prostate cancer? Year: _____

Have you ever had an abnormal PSA test? ☐ Yes ☐ No If yes, when? Year: _____

When was your last testicular check? Year: _____