Chhaya Medical Services Pty Lty

Flagstone Pioneer Health

Confidential Patient Medical History Form

Name: _____ Date of Birth: _____/_____/_____

PAST MEDICAL HISTORY - Please list any serious illnesses, operations, hospital admissions

YEAR	DETAILS

Have you suffered from any of the following – currently or in the past? Please tick √

- ☐ HYPERTENSION (HIGH BLOOD PRESSURE)
- ☐ CHOLESTEROL
- ☐ DIABETES
- ☐ ASTHMA
- ☐ COPD / EMPHYSEMA
- ☐ LUNG PROBLEMS
- ☐ HEARING PROBLEMS
- ☐ VISUAL PROBLEMS
- ☐ EPILEPSY
- ☐ ANY MIGRANES
- ☐ TIA / MINI STROKE / STROKE
- ☐ UNDERACTIVE THYROID / OVERACTIVE THYROID
- ☐ ANGINA / MI / IHD / CABG
- ☐ RHEUMATISM OR ARTHRITIS
- ☐ BOWEL PROBLEMS
- ☐ URINARY PROBLEMS
- ☐ JAUNDICE / LIVER PROBLEMS
- ☐ BREAST PROBLEMS
- ☐ ACNE / ECZEMA
- ☐ MELANOMAS / CYSTS / SKIN CANCER
- ☐ DEPRESSION / ANXIETY
- ☐ PROSTATE

Do you have any Allergies – in particular to any medications?

NAME	REACTION

CURRENT MEDICATION – (If none write NIL). Please list ANY tablets / injections or inhalers you are taking.

NAME OF MEDICATION	DOSE IF KNOWN

FAMILY HISTORY – Has anyone in your family suffered from the following?

DISEASE	WHO	WHAT AGE
HEART DISEASE		
HIGH BLOOD PRESSURE		
STROKE		
BLOOD CLOTS		
DIABETES		
THYROID DISEASE		
OSTEOPOROSIS		
BREAST CANCER		
CERVIX / OVARY / WOMB CANCER / BOWEL CANCER		

LIFESTYLE

○ EX SMOKER/ NON SMOKER ○ SMOKER ○ ALCOHOL

FEMALE PATIENTS ONLY

WHEN WAS YOUR LAST MAMMOGRAM? _____

WHEN WAS YOUR LAST PAP SMEAR? _____ ○ Normal ○ Abnormal

ANY CONTRACEPTION? (PLEASE SPECIFY WHICH ONE) _____

Patients Signature: _____ Date: _____

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