



Chhaya Medical Services Pty Ltd Greenbank 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

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

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		
<input type="radio"/> EX SMOKER/ NON SMOKER	<input type="radio"/> SMOKER	<input type="radio"/> 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: _____