NEW PATIENT HISTORY

Please complete BOTH SIDES and hand to Doctor

FIRST NAME(s) _____ **FAMILY NAME** _____

DATE OF BIRTH _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☐

Name of medication	Type of reaction
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS AND DOSE (including vitamins and over-the-counter medications):

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY:

	YES	NO	Who
Breast Cancer	☐	☐	_____
Bowel Cancer	☐	☐	_____
Melanoma	☐	☐	_____
Other cancer	☐	☐	_____
Type _____			_____

	YES	NO	Who
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Depression	☐	☐	_____

Other family history _____

PAST OPERATIONS AND SERIOUS ILLNESSES: Date

_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation_____ Lives with_____

Recreational activities _____

Are you an elite athlete? YES ☐ NO ☐ Are you breastfeeding? YES ☐ NO ☐

Please complete BOTH SIDES and hand to Doctor

IMMUNISATIONS:

If completing this form for a child, are their immunisations up to date? YES ☐ NO ☐

Have you had the following Immunisations?

	Date: _____	Don't know ☐	Haven't had one ☐
Tetanus	Date: _____	Don't know ☐	Haven't had one ☐
Hepatitis A	Date: _____	Don't know ☐	Haven't had one ☐
Hepatitis B	Date: _____	Don't know ☐	Haven't had one ☐
Influenza	Date: _____	Don't know ☐	Haven't had one ☐
Pneumococcal	Date:	Don't know ☐	Haven't had one ☐
Whooping Cough	Date: _____	Don't know ☐	Haven't had one ☐
Polio	Date: _____	Don't know ☐	Haven't had one ☐
Gardasil 1	Date: _____	Don't know ☐	Haven't had one ☐
Gardasil 2	Date: _____	Don't know ☐	Haven't had one ☐
Gardasil 3	Date: _____	Don't know	Haven't had one
Other _____	Date: _____		
Other _____	Date: _____		

SMOKING & ALCOHOL HISTORY:

Do you smoke? How much & how long? _____

Do you drink alcohol? How much & how often? _____

Do you use recreational drugs? What kind & how often? _____

FOR FEMALES:

Date of last Pap Smear Test _____ Result _____

Have you ever had a GP Management Plan completed by your doctor? _____

If yes, date of last plan _____

Have you ever had a GP Mental Health Plan completed by your doctor? _____

If yes, date of last plan _____

Any other information relevant to your health _____

_____

Name of person completing this form _____

Relationship to patient (e.g. self, mother etc.) _____ Date _____