BRASSALL CLINIC – Medical Questionnaire

Please complete this confidential medical history form to allow your doctor to accurately treat you. Once completed this form is to be handed to your doctor at your consultation. If there are any sections you prefer not to answer please feel free to leave them blank.

Full Name		**Date of Birth**	/ /

CURRENT MEDICAL CONDITIONS					
Have you suffered from any or currently have any of the following?					
☐ High Blood Pressure	☐ Thyroid Disease	☐ Chronic Illness	☐ Stomach Ulcers	☐ Heart Disease	☐ Asthma
☐ High Cholesterol	☐ Emphysema	☐ Diabetes	☐ Epilepsy	☐ Blood Clots	☐ Cancer
☐ Other (please specify)					

CURRENT MEDICATIONS	
Please list any tablets/injections that you are currently taking. Please include the contraceptive pill and any vitamins or "natural remedies" that you may be on.	
Medication Name	**Dose if Known**

ALLERGIES		
Do you have any allergies? If so please list the allergies, type of reaction that you have and any medication that is taken for them.		
Allergy	**Reaction**	**Medication**

PAST MEDICAL HISTORY	
Please list any serious illnesses, operations, hospital admissions that you have had or currently have (if none please white nil)	
Details	**Year**

PAPSMEAR/MAMMOGRAM	
When was your last pap smear?	
If you have ever had an abnormal pap smear result, please list	
When was your last mammogram?	
If you have ever had an abnormal mammogram result, please list	

VACCINATIONS					
Please indicate if you have ever had any of the following vaccinations. If you are unsure mark unsure					
Vaccination	**Year**	**Vaccination**	**Year**	**Vaccination**	**Year**
Hepatitis B		Gardisil		Tetanus	
Measles		Whooping Cough		Hepatitis A	
Influenza (flu)		Pnuemcoccal		Typhoid	
Other (please specify)					

LIFESTYLE							
Occupation							
Smoker	☐ Yes currently	**How many per day?**		☐ Ex Smoker	**In the past per day?**		☐ No Never
Alcohol	☐ Yes currently	**How many per day?**		☐ Ex Drinker	**In the past per day?**		☐ No Never
Drugs	☐ Yes currently	**Type**		☐ Ex User	**Type**		☐ No Never

FAMILY HISTORY		
Has anyone in your close family suffered from the following conditions?		
Disease	**Who**	**How Old Were They**
Heart Disease		
High Blood Pressure		
Stroke		
Blood Clots		
Diabetes		
Bowel Cancer		
Prostate Cancer		
Breast Cancer		
Cervical Cancer		
Other type of cancer (please specify)		
Other (please specify)		

FINALLY

Please indicate what topic is of particular concern to you today?