New Patient Medical Information Form (completed form to be given to Dr)

Date: **Name:** **Date of Birth:**

BIRTH SEX: ☐ Male ☐ Female ☐ Other ☐ Unknown ☐ Prefer not to answer

GENDER IDENTITY:
☐ Male ☐ Female ☐ Non-binary ☐ Gender diverse
☐ Transgender ☐ Different identity ☐ Prefer not to answer

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?
☐ No ☐ Yes – provide details:

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

MEDICAL HISTORY - Do you have or have you had a history of the following?
☐ Surgery – provide details:
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other – provide details:

LIFESTYLE RISK FACTOR INFORMATION

Smoking
☐ Non Smoker ☐ Ex Smoker ☐ Smoker
Current Use: Cigarettes per day _____ Year Started_____
Past Smoking History: Cigarettes per day _____ or Unknown
Year Started _____ Year Stopped_____

Alcohol
☐ Non Drinker ☐ Drinker
Days per week____ Standard drinks per day_____
Past Alcohol Intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Recreational Drug Use
☐ No ☐ Yes - Type_____ Frequency _____

Family Health History Information

Do any members of your family have:
☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Hypertension (high blood pressure)
☐ Mental Illness
☐ Cancer – type:
☐ Other significant - provide details:

Date of last check up_____

If Applicable Date of last Cervical Smear_____

Date of last Mammogram_____