# The Doctors Massey Medical - Medical Information Form

1/01/2010

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|---|---|
| **Name:** | **Ethnicity:** |
| **Date of Birth:** | **Male/Female:** |

| **Current or Past Illnesses** | | | |
|---|---|---|---|
| | Specify if applic. | Yes | No |
| High Blood Pressure | | | |
| Diabetes: Type 1 or 2 | | | |
| Angina/heart attack | | | |
| Stroke/cva | | | |
| High Cholesterol | | | |
| Kidney Disease | | | |
| Cancer-including skin | | | |
| Asthma/Lung Disease | | | |
| Surgery | | | |
| Depression/anxiety | | | |
| Epilepsy | | | |

| **Has any immediate member of your family had...** | | | |
|---|---|---|---|
| | Specify | Yes | No |
| High Blood Pressure | | | |
| Diabetes: Type 1 or 2 | insulin/tablets | | |
| Angina/heart attack | | | |
| Stroke/cva | | | |
| High Cholesterol | | | |
| Kidney Disease | | | |
| Cancer | | | |
| Asthma/Lung Disease | | | |
| Osteoporosis | | | |
| Depression/anxiety | | | |

| **Social History** | | | |
|---|---|---|---|
| | Specify | Yes | No |
| Do you smoke | | | |
| If yes, no. Per day | | | |
| No. years smoking | | | |
| If ex-smoker, when did you stop? | | | |
| Any recreational drugs | | | |
| Do you drink alcohol | | | |
| How many drinks/week | | | |
| How many drinks/week | | | |

| **List your current medication** | |
|---|---|
| Name of medicine | dosage |
| e.g.Lipex | 20mg once daily |
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| **Screening - When was your last...** | |
|---|---|
| | Notes & Year if known |
| Cervical Smear (women) | |
| Have you had an abnormal | |
| smear - specify if known | |
| Is your smear overdue | |
| Mammogram (women) | |
| Tetanus Vaccination | |
| Flu Vaccine | |
| Prostate examination (men) | |

| **Please List Any Allergies** | |
|---|---|
| **Medication** | **Type of Reaction** |
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| **Other information you wish to inform us about** | |
|---|---|
| If you know your current weight & height please list it here | |
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