Grace Family Practice & Skincare

Medical History Form

Please fill out the following questions regarding your medical history:

Name:_____ **DOB**_____

Are you under any Medical Specialists? Y ☐ **N** ☐ **If so; who/conditions:** _____

_____

Do you have any allergies? - Medications, non drug or other (please specify)

Allergy:	Reaction:	Allergy:	Reaction:

Operations and / or Hospitalizations: List below with approximate date:

Reason:	Date:	Reason:	Date:

Medical History: Tick box if you have ever had any of the following:

Respiratory Conditions	✓	Neurological Conditions	✓	Liver Conditions (specify):
Emphysema/Chronic Bronchitis		Stroke		
Asthma		TIA/Mini stroke		Kidney Conditions (specify):
Other (specify):		Dementia/Alzheimer's		
		Epilepsy/seizure conditions		Skin Conditions (specify):
Cardiac Conditions		Other (specify):		
Heart attack				Eye Conditions (specify):
Angina/chest pain		**Cancer**		
Heart failure/CCF		Current ☐ Previous ☐		Muscular Conditions (specify):
Abnormal rhythms (specify):		Location/Type (specify):		Bone/Skeletal Conditions (specify):
High blood pressure				
Other(specify):				Stomach/Intestinal (specify):
		Communicable Diseases		
Endocrine/Hormonal Conditions		HIV/AIDS		Other relevant(specify):
Diabetes: Type 1 ☐ Type 2	☐	Hepatitis: Current ☐ Previous	☐	
Thyroid conditions (specify):		Hep A ☐ Hep B ☐ Hep C	☐	
Other (specify):		Other (specify):		

Smoking History: Never ☐ **Current** ☐ **-No. per day**_____ **Ex-Smoker** ☐ **-yrs since quitting**_____

Alcohol History: No. Days per week alcohol consumed_____ **No. Drinks per day**_____

Weight (kg): _____ **Height:**_____

Signature_____ **Date:**_____

Please keep this Medical History form with you and hand it to your doctor during your appointment.