Patient Medical History					
Medical Condition	**Yes**	**No**	**Medical Condition**	**Yes**	**No**
Anaemia			Gout		
Arthritis			Hypertension		
Asthma			Heart Condition		
AIDS/HIV			Hepatitis		
COPD: Chronic Bronchitis/Emphysema			Hernia		
Convulsions			Kidney/Urinary Conditions		
Cataract			Migraine		
Diabetes			Stroke		
Depression			Thyroid Problems		
Epilepsy/Seizures			History of previous surgery		
Glaucoma			Other significant medical condition(s)		
If yes please specify:					

Family History (i.e. stroke, hypertension, diabetes, asthma etc.)			
Father	Age:	☐ Alive or ☐ Deceased	☐ Healthy or ☐ Not So Healthy
	Medical Conditions:		
Mother	Age:	☐ Alive or ☐ Deceased	☐ Healthy or ☐ Not So Healthy
	Medical Conditions:		
Siblings	Age(s):	Number of Brothers:	Number of Sisters:
	Medical Conditions:		

Patient Medications (including over the counter drugs)		
Drug Name	**Dosage**	**Frequency**

Vaccination History (if unknown please state)	
Vaccine	**Date Last Given**
Hepatitis B Vaccine	
Influenza Vaccine	
Measles/Mumps/Rubella Vaccine	
Tetanus Vaccine	

Mammogram and Smear History			
Procedure	**Never**	**Up to Date (specify date)**	**N/A (e.g. hysterectomy)**
Mammogram			
Smear			

Name: _____ Date: _____