# Confidential Patient Medical History Form

**Surname: …….. Given Name: …… D.O.B: …….**

**Allergies:**
Do you have any allergies? ☐ Yes (Please specify) ☐ No
_____

**Smoking:** Smoker ☐ Ex-Smoker ☐ Never Smoked ☐

Start date: ……. Quit date: …… Number of cigarettes per day: …….

**Alcohol:**

How often do you have a drink containing alcohol:

***Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week ☐***

How many standard drinks containing alcohol on a typical day:

**1 or 2 3 or 4 5 or 6 7 to 9 10 or more**

How often do you have six or more drinks on one occasion:

***Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐***

**Immunisations:**

Are your immunisations up to date? Yes ☐ No ☐ Unsure ☐

***Height:*** _____ ***Weight:*** _____ ***Waist:*** _____

**Family History:**

Is there any history of cancer, diabetes, high blood pressure …… please provide details below:
_____

_____

_____

**I certify that this information is true and correct to the best of my knowledge.**

Patient signature:_____ Date:_____