Middle Ridge Family Practice
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New Patient Medical History Form

Your Health is Our Priority

PATIENT DETAILS		
Surname:	Given Name:	Date of Birth :

PATIENT HISTORY

Do you have any allergies and if yes, what is the reaction:

Do you have a EPOA or Advanced Health Directive: ☐ Yes ☐ No
If yes, what is the name and phone number of your EPOA:

Female Patients: Have you ever had a PAP smear? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No

Family History: ☐ Unknown ☐ No significant family history

Maternal History:
Does your mother have or ever had any of the following:
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon ☐ Cancer ☐ Depression ☐ Breast Cancer
☐ Osteoporosis ☐ Dementia ☐ Alzheimer's
Other (Please Specify): _____ Current Age: _____ or Age at Death: _____

Paternal History:
Does your father have or ever had any of the following:
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon ☐ Cancer ☐ Depression ☐ Prostate problems
☐ Dementia ☐ Alzheimer's
☐ Other (Please Specify): _____ Current Age:: _____ or Age at Death: _____

SOCIAL HISTORY	
Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Widowed ☐ Separated	Elite Athlete? ☐ Yes ☐ No
Lives with: ☐ Alone ☐ Spouse ☐ Relative/Parents ☐ Friend	Are you a Carer: ☐ Yes ☐ No
Do you have a Carer: ☐ Yes ☐ No	Carer Details:

MEDICATION HISTORY

Current Medications:

Complementary Medications (e.g. Multivitamins):

SMOKING HISTORY	
Do you smoke? ☐ Yes ☐ No	If yes, how many per day?
Past Smoking History: ☐ Light ☐ Moderate ☐ Heavy	Which year did you stop smoking?

ALCOHOL CONSUMPTION HISTORY		
Do you drink alcohol? ☐ Yes ☐ No	If yes, how many standards per day?	How many days per week?

Past Alcohol Consumption : ☐ Occasional ☐ Moderate ☐ Heavy