NARRE WARREN
MEDICAL CENTRE

New Patients Medical History

2/3 Malcolm Court, Narre Warren 3805 *Ph: (03) 9704 6812 *Fax: (03)9704 0509

Dr Craig Mulligan
Dr Peter Burr
Dr Leanne Myerscough
Dr Kumuthini Kantheepan
Dr Somnath Ghosal

Surname: _____ First Name:_____

Date of Birth: ____/____/_____

Medical History

Do you have any allergies to medicines, or anything else? ☐ YES ☐ NO

- To what ? _____
- Reaction?_____
-

Current Medications (Including over the counter medication)

Name of Medication	Strength	Times taken

Have you ever had any major operations or been admitted to hospital?

Year	Reason

Family History:

Has anyone related to you ever had	Relationship	Ever had ✔	Age of onset	Died from ✔	Age
High blood pressure					
High cholesterol					
Heart attack/ angina					
Stroke					
Anaemia					
Bleeding disorder					
Asthma/ emphysema					
Tuberculosis					
Arthritis					
Diabetes					
Kidney disease					
Cancer or tumor					
	Type:				
Other _____					

Have you ever had:	Have you had?	Active now?		Have you had?	Active now?
Heart problems			Serious infection		
Angina			Skin rashes, dermatitis, eczema, psoriasis		
High blood pressure			Epilepsy/ fits/ blackouts/ strokes		
High cholesterol			Migraine		
Varicose veins, clots or blocked arteries			Asthma/ emphysema		
Stomach ulcers			Hay fever/ sinus problems		
Gall stones			Eye/ ear problems		
Liver disease, Jaundice, Hepatitis			Back/ neck problems		
Pancreatitis			Serious Trauma		
Hernia/ bowel problems			Emotional disorder/ stress		
Rectal bleeding			Kidney/ urine/ bladder problems		
Diabetes			Prostrate problems/ impotence		
Thyroid problem			Abnormal pap smear		
Gout			Sexually transmitted disease		
Arthritis/ Joint problems			AIDS		
Cancer (where?)					

Immunisations: (if known)

	✔	Year *(if known)*		✔	Year *(if known)*
Birth			Rubella		
2 month			Hepatitis A		
4 month			Hepatitis B		
6 month			Meningococcal		
12 month			Typhoid		
18 month			Chicken Pox		
4 year			Influenza		
Year 7			Pneumonia		
Year 10			Measles		
Tetanus			Cholera		

Preventative Health

When was your last check for the following:

	YEAR		YEAR
Cholesterol		Bowel cancer	
Blood Pressure		HIV test	
Prostate check		Hepatitis test	
Pap smear			

Social	Yes	No	Yes, current	Usage
Smoker				_____per day
Alcohol consumption				_____per week
Illicit drug use				_____
Exercise				_____