New Patient History Information Sheet:

Name:_____ D.O.B:_____

Address:_____

Do you have any Allergies- Food, Medicines etc., List? _____

Please list any medications (dosage and frequency), herbal medicines etc.. that you are currently taking?

_____
_____
_____
_____
_____

Do you have a history of any past illnesses, asthma, hayfever, diabetes, broken bones, operations?

_____
_____
_____
_____
_____

Do you have any family history of illness- diabetes, asthma, cancer, heart disease etc.- in whom?

_____
_____
_____
_____
_____

Have you ever smoked? Yes / Not now / Never If Yes, how much/day? _____

If not now, when did you give up? _____

Do you drink alcohol? Yes / No How often?_____ How much in one sitting?_____

Do you exercise regularly ? Yes / No

Any hobbies or interests? _____

Are all your immunisations up to date? Yes / No / Don't know.