New Patient Health History Form

All questions obtained in the form are strictly confidential and will be used solely for Central Health Alliance Patient Medical Records.

Name:	D.O.B: M ☐ F ☐	Occupation:

Personal Medical History

Do you have Allergies / Adverse Reactions?	Yes ☐ Nil Known ☐	
Name of drug / Food / Product	Reaction (e.g. Rash, vomiting)	Severity

Recent and Past Medical Conditions:

☐ Diabetes Type:	☐ Depression
☐ Stroke	☐ Anxiety
☐ Heart Disease	☐ Asthma
☐ High Blood Pressure	☐ Skin Condition Type:
☐ Cancer Type:	☐ Other:

Smoker

☐ Yes How many per day?	☐ No	☐ Ex-smoker How many per day?

Alcohol Intake

☐ Yes How many per day?	☐ No	☐ Ex-drinker How many per day?

Family Medical History

Mother: Alive ? Y / N Age of death:	Father: Alive? Y / N Age of death:

Tick below for conditions that apply – Circle M for mother's side and F for father's side

☐ Diabetes Type:	M / F	☐ Depression	M / F
☐ Stroke	M / F	☐ Anxiety	M / F
☐ Heart Disease	M / F	☐ Asthma	M / F
☐ High Blood Pressure	M / F	☐ Skin Condition Type:	M / F
☐ Cancer Type:	M / F	☐ Other:	M / F

Current Medications: (include prescribed drugs, over the counter and vitamins)

Name of Medication and Dose	Reason Medication being taken	How long have you been taking it?

Recent/Past Surgeries or Hospitalizations

Year Occurred:	Reason:

Women ONLY

Contraceptive Use (if using implanon state last insertion date)	
Date of last PAP	
Date of last Breast Screen	

Men Only

Date of last Prostate Check	

Sign and date below to consent to the above information being uploaded to your CHA patient file.

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