ATTICUS HEALTH
Driven by Soul

General Practice | Telehealth | Aged Care | WorkplaceHealth

New Patient - Medical History

Name:

Allergies and Medicines
Please list allergies and intolerances

_____
_____
_____
_____

Please list all current medications (including over the counter medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family History

Do you or any members of your family been diagnosed or suffered from:

☐ Diabetes: _____

☐ Asthma: _____

☐Heart Disease: _____

☐ Mental Illness: _____

☐Cancer: _____

Social History

☐ I have never smoked ☐ Ceased smoking: ___/___/___ ☐ ____ per day / week

Alcohol

☐I do not drink alcohol ☐ _____ per week ☐_____ per day ☐_____ per month

Recreational Drugs

☐ Type: _____ ☐ Frequency _____

How often do you exercise or engage in physical activity for 30 minutes or more?

☐ Daily ☐ _____ per week ☐ Never ☐ Other: _____

Occupation: _____

If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

Is there any other information that you believe we should know that may affect or have an influence on the medical treatment / advice you will be provided with?

If yes, please provide details below

_____
_____
_____
_____