Dr Elsa New Concept Clinic – Patient Medical Questionnaire

Name: _____ **DOB:** _____ / _____ / _____
dd mm yyyy

Are you pregnant? ❑ YES ❑ NO

Do you have any allergies? ❑ YES ❑ NO
If you answered yes, please comment below:
Medications:_____
Other : (e.g.Foods , Latex)_____
Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. YES ❑ NO ❑
Comments: _____

Current Medical History

Are you seeing any doctor or specialist for any other medical conditions ? YES ❑ NO ❑
Comments _____

List any current medications or treatment: _____

Medical History & Surgical History

Have you ever been treated for any of the below ?

Tick those questions to which your answer is yes (leave others blank).

- ☐ Heart disease (i.e. high/ low blood pressure, high cholesterol)
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Gastric problems
- ☐ Thyroid problems
- ☐ Anaemia / Any other blood disorders including clotting or bleeding irregularities, sickle cell or thalassemia
- ☐ Neurological disorders
- ☐ Anxiety or emotional problems
- ☐ Spinal problems
- ☐ Gynaecological infections
- ☐ Any other problems not listed above ?
- ☐ Any surgery in the past ?
- ☐ Have you received any type of anaesthesia in the past ?

Comments if yes to any of the above:

_____

_____

_____

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Familial Diseases

Do you have a parent or sibling with a history of the following?

Tick those questions to which the answer is yes (leave others blank).

- ☐ Cardiac problems (high BP, stroke, heart attack , high cholesterol)
- ☐ Diabetes
- ☐ Cancer
- ☐ Birth conditions/abnormalities

Comments If yes to any of the above:

_____

_____

_____

Obstetric and Gynecology History

- ☐ What day did your last period start ? ----------
- ☐ Have you ever been pregnant? If yes, how many pregnancies: ?____ Any miscarriages ?-----
- ☐ How many deliveries:? _____
- ☐ Type of delivery ? ----------
- ☐ Any problems in labour ?----------
- ☐ Any problems after your delivery ? ----------
- ☐ When was your last pap smear ? ----------
- ☐ Have you ever had an abnormal pap smear ? ----------
- ☐ When was this ? ---------- Did you have further treatment ?----------

Life Style

Smoking

Do you smoke tobacco ?

☐ Yes ☐No

If you did or now smoke cigarettes, how many per day? _____

If you have stopped smoking, when was it? _____

Do you ever drink alcoholic beverages?

☐ Yes ☐ No

If yes, what is your approximate intake?

☐ Occasional ☐ Often If often how many glasses per week, _____

To the best of my knowledge, the above information is correct: PATIENT/PARENT/GUARDIAN (please circle)

SIGNATURE: _____ **DATE**: _____ / _____ / _____

dd **mm** **yyyy**