MOFFAT BEACH FAMILY MEDICAL PRACTICE

Patient Health Summary – Female

Please complete the following information to help us provide you with the best possible care

Surname: _____ First name: _____ Age: ____ Occupation:_____

Please list all medications:

_____

_____

_____

_____

Any known allergies or sensitivity to any medication, foods or dressings:

_____

Ongoing medical conditions: eg high blood pressure, depression, arthritis etc.

_____

_____

Past medical/surgical conditions:

_____

_____

_____

Family History of note: (history of illness or disease in your immediate family ie diabetes, cancer, heart disease)

_____

_____

Recent medical tests:

☐ Pap smear – date _____ ☐ Mammogram – date _____ ☐ Cholesterol check – date _____

LIFESTYLE RISK FACTORS:

Smoking:

☐ Non-smoker ☐ Smoker No. per day _____ ☐ Ex-smoker Quit date _____

Alcohol:

How often do you have a drink contained alcohol?

☐ never ☐ monthly or less ☐ 1-2 times/month ☐ 2-3 times/week ☐ 4 or more times/week

How many standard drinks contained alcohol do you have on a typical day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7-9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?

☐ never ☐ monthly or less ☐ monthly ☐ weekly ☐ daily or almost daily

Are you concerned about your drinking? ☐ Yes ☐ No

Immunizations:

☐ Tetanus ☐ Influenza ☐ Pneumonia ☐ Other _____

List any concerns that you would like to discuss with your doctor:

_____

_____

_____

_____

Office use only:

Date:_____ Ht:_____ Wt:_____ Waist:_____BP:_____