MOFFAT BEACH FAMILY MEDICAL PRACTICE

Patient Health Summary - Male

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

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Surname: ______________________ First name: _________________ Age: ____ Occupation:___________________

Please list all medications:

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

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

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Past medical/surgical conditions:

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

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Recent medical tests:
☐ Prostate level - 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:

☐ Frequent urination ☐ Painful urination ☐ Inability to control urination ☐ Night time urination

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Office use only:

Date:___________ Ht:______________ Wt:______________ Waist:_____________BP:_______________