Better Medical

Medical/ Social History Information Update Form

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Mast ☐ Miss ☐ Dr ☐ Prof ☐ Other	
Family name		
Given name/s		Preferred name
Date of birth	/ /	Birth sex ☐ Female ☐ Male ☐ Other ☐ Unknown
Contact details	Mobile Home Work	
Email		
Preferred contact	☐ Mobile ☐ Work ☐ Home ☐ Email	
Medical history	Do you have, or have you had a history of: ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Colon cancer ☐ Depression ☐ Heart disease ☐ Breast cancer ☐ Past surgeries ☐ Other significant	
Family health history	Have any members of your family had: ☐ Diabetes *(mother, father, other?)* ☐ Depression *(mother, father, other?)* ☐ Colon cancer *(mother, father, other?)* ☐ Past surgeries *(mother, father, other?)* ☐ Breast cancer *(mother, father, other?)* ☐ Stroke *(mother, father, other?)* ☐ Hypertension *(mother, father, other?)* ☐ Heart disease *(mother, father, other?)* ☐ Other significant *(please elaborate)*	
Marital status	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widow	
Advanced Care Directive	Do you have an Advanced Care Directive in place? ☐ Yes ☐ No *(if this is of interest, further information is available in the clinic)*	
Substitute Decision Maker	Do you have a substitute decision maker? ☐ Yes ☐ No	
	If yes, please provide their details below. Title: Family Name: Given Name/s: Home phone number: Mobile phone number:	
Who do you live with?	☐ Spouse ☐ Relative ☐ Friend ☐ Alone	
Do you have a carer?	☐ Yes ☐ No If yes, please provide their details below. Title: Family Name: Given Name/s: Home phone number: Mobile phone number:	

Current smoking intake	☐ Non-smoker ☐ Ex-smoker ☐ Smoker
If you ticked smoker	What do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Other *(please state)* How many do you smoke per day? ☐ < 1 ☐ 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+ Year started?
If you ticked ex-smoker	What did you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Other *(please state)* How many did you smoke per day? ☐ < 1 ☐ 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+ Year started? Year stopped?
Current alcohol intake	☐ I don't drink alcohol ☐ I used to drink alcohol ☐ I currently drink alcohol
If you ticked I currently drink alcohol	Days per week you have an alcoholic drink? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Standard drinks per day? Year started? Comments/details:
If you ticked I used to drink alcohol	How many days per week did you have an alcoholic drink? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Standard drinks per day? Year started? Year stopped?
Allergies (drugs or other)	☐ No known allergies ☐ Known allergies
If you ticked known allergies	Allergy: Nature of reaction: Severity *(please circle)*: Mild Moderate Severe
	Allergy: Nature of reaction: Severity *(please circle)*: Mild Moderate Severe
	Allergy: Nature of reaction: Severity *(please circle)*: Mild Moderate Severe
Current medications	Please list your current medications, including complementary and over-the-counter medicines (e.g. vitamins and minerals) and natural therapies.