Dickson-Hall Medical Consulting New Patient History & information sheet

Dear New Client,

We'd like to extend a warm and sincere welcome to our practise!

We look forward to working together with you in order to optimise your health and wellness.

Since this is your first consultation, we'd like to take the time to get to know you and your medical and family background a little better, in order to provide a more optimal and individually centred service to you and your loved ones.

No fields are compulsory, so if you should you prefer not to answer any of the questions below, or would prefer to answer them at another consult, simply omit it / them and continue onwards with the form. All information provided will be treated as confidential.

If you think we need more detail on any of the fields or questions, please continue the information on the paper provided at the back of the questionnaire.

Many thanks!

A. Basic details and information:

1	Title (Dr, Mrs, Ms, Mr, Rev, Sgt, Col, etc)		
2	Surname		
3	First Names		
4	Calling or preferred name, for the practise to call you as.		Pronouns
5	Maiden or previous surname		
6	Date of birth		
7	Age at last birthday		
8	ID / passport no		
9	Medical Aid		
10	Medical Aid option / plan		
11	Medical Aid no		
12	Main member of Medical Aid		
13	ID no of main member of medical aid		
14	Street address		
15	Email address	*(Large print please)*	
16	Cell phone no		
17	Home no		
18	Next of kin name, relation & cell no		
19	Religion		
20	Blood and / or organ donor		
21	Living Will		

B. Medical History: Due you experience any of the following conditions of the body systems? If so, please provide detail:

1	Neurological	Epilepsy, stroke, aneurism
2	Endocrine	Diabetes, autoimmune conditions, Polycystic ovaries, Metabolic syndrome, thyroid disorders
3	Gastroenterological	Irritable Bowel Syndrome, Crohn's, Ulcerative colitis, Peptic ulcers
4	Dermatological	Rashes, Eczema, cosmetic fillers, etc
5	Cardiac	Heart Attacks, rhythm abnormalities, valve disorders, High blood pressure
6	Pulmonary	TB, Asthma, Emphysema
7	Renal	Nephritis, Nephrotic syndrome, Chronic kidney disease
8	Rheumatoid	Arthritis (rheumatoid), Lupus
9	Haematological	Factor or clotting deficiencies / abnormalities, anaemia
10	Oncology	Cancers
11	Orthopaedic	Osteoporosis
12	Infections	HIV, Hep B / C, TB
13	Eye conditions	Cataracts, glaucoma
14	Psychiatric	Depression, anxiety, Bipolar mood disorder, ADHD, suicide attempts, substance dependency (alcohol, drugs, meds), anorexia, bulimia
15	Allergies	Medication, food, latex, Elastoplast, etc
16	Other	

C. Surgical (operations) History (please supply date, surgeon & hospital)

1	Vascular	Vessel disease, grafts, bypass, varicose vein surgery
2	Cardiac	Heart Bypass, valve replacements, trauma repairs
3	Orthopaedic	Fractures (broken bones), grafts, replacements
4	Pulmonary	Resections, lobectomies, chest drains
5	Neurological	Brain surgery, spinal surgery
6	Dermatology	Cancers, grafts

7	Oncology	Cancer surgeries
8	Ophthalmological	Eye operations
9	ENT	Tonsillectomy, adenoidectomy, sinusitis, ear, allergic rhinitis (hay fever)
10	Dental	Wisdom tooth extraction, implants
11	Gastroenterological	Ulcer, bypass, bariatric (for obesity), bowel obstruction, colon resection, appendectomy
12	Eye	Cataracts, foreign bodies, enucleation, retinal detachment
13	Renal / adrenal	Biopsy, removal
14	Urological	Prostate enlargement / removal, frequent UTI's (bladder infections), pyelonephritis
15	Transplantation	Heart, Lung, pancreas, kidney, cornea
16	Cosmetic surgery	Implants, reductions, liposuction, etc
17	Endocrine	Thyroid, parathyroid
18	Ports / IV access	Dialysis, Chemotherapy
18	Other	

D. Medication history:

	Name	Dose / how often a day or week the medication is taken
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

E. Obstetric History (female patients)

1	Are you on Family planning? If so, which method?	
2	Do you desire a pregnancy in the near (6month) future?	
3	Have you had previous pregnancies? If so, please supply details:	

4	Did you experience any problems during the pregnancy/ies eg: Blood pressure, sugar, depression, etc?	
5	Have you previously given birth, if so, please supply details:	
6	Did you experience any problems during the birth/s eg: fits, bleeding, infection	
7	How old are your children now?	
8	Did your babies experience any problems after birth?	
9	Have you previously been treated for STI (vaginal warts, infections other than thrush, herpes, syphilis, and gonorrhoea)?	
10	Have you been diagnosed with endometriosis?	
11	Have you had gynae surgery eg: Ectopic pregnancy, laparoscopy, ablation, hysterectomy, oophorectomy (ovaries), ovarian cyst removal?	
12	When last did you have a PAP smear & what was the result?	
13	Have you had any symptoms of change of life / menopause?	

F. Family & household history:

1	Does any one of whom you are related by blood (mother, sister, first cousin) have any illnesses eg: Cancer, autoimmune illnesses, diabetes, asthma, epilepsy, heart problems, thyroid problems, TB, nerve or muscle diseases, cholesterol issues, osteoporosis, mental health problems?	
2	Does anyone in your immediate family (partner, children) have any major illness?	
3	Is anyone in your household currently very ill or disabled?	
4	Does anyone in your family or household have problems with alcohol or drug use?	
5	Do you live with children or adolescents with behaviour disorders or challenges?	

6	Is your house very close to electric pylons, cell phone towers, major freeways, factories or airports?	
7	Do you currently live together with others?	
8	Do you live together with family pets? If so, please provide details.	
9	If you are older than 55yrs, do you have plans or bookings for retirement accommodation?	
10	Does your household very dependent on stairways for access?	

G. **Accident or trauma injury history,** eg: fall, car collision, gunshot wound, assault

H. **Major adverse life event history,** eg: hijacking, armed robbery, interpersonal violence, witnessing a traumatic event, divorce or separation, retrenchment, death of a child or partner, diagnosis of a life threatening illness, adverse legal or financial event, emigration

I. Occupational History:

1	Current occupation	
2	Previous occupation/s	
3	Current employer	
4	Qualifications	
5	Current studies	

6	Exposure to chemicals, radiation, paint, laboratories, patients, aviaries, nurseries, noise, mines?	
7	Exposure to night shifts, extended working hours?	
8	No of hours worked on an average week?	
9	Frequency & duration of vacations?	

J. Diet & intake history:

1	Do you follow any particular diet, eg: vegan, vegetarian?	
2	Are you currently on diet, eg: Weigh less?	
3	Do you have any food allergies / sensitivities?	
4	How many times a week do you eat fast food from a 'take out' venue?	
5	How many portions of fruit & veg do you usually eat daily?	
6	How many cups of coffee do you drink daily?	
7	How many servings of alcohol do you drink / week?	
8	What do you usually eat for breakfast?	
9	Do you use any vitamins / supplements?	
10	Do you smoke? If so, at what age did you start & how many do you smoke per day?	
11	Do you engage in recreational drug use? If so, what substances do you use & how often are you using?	

K. Transport & exercise history:

1	Do you belong to a 'gymn' or exercise club & attend regularly?	
2	Do you walk / run /cycle / swim / row during the week?	
3	Are you currently training for a particular event?	
4	Have you any history of sports injuries?	
5	Do you attend yoga / aerobics classes?	
6	Do you use public transport (taxi, train, bus) during the week?	
7	Do you walk / cycle to work?	

L. Travel history:

1	Do you travel during the year internationally? If so, to which countries?	
2	Do you travel during the year within Africa? If so, to which countries?	
3	Do you travel during the year, to regions of Malaria risk? If so, do you use malaria prophylaxis?	

M. Would you like to be referred to any of the following: (Tick if 'yes')

1	Dietician	
2	Podiatrist (foot / nail care)	
3	Weigh less program	
4	Run / walk for Life program	
5	Smoke enders program	
6	Psychologist	
7	Support group (for any variety of conditions / situations / illnesses)	
8	Chiropractor / physiotherapist	
9	First Aid / CPR course	
10	Other:	

N. Would you be interested in the following (Tick if 'yes'):

1	Flu vaccine, Hep B vaccine, Hep A vaccine	
2	IUCD (eg: Mirena for family planning)	
3	Advise on HIV prevention, STI prevention, PAP smears, Prostate screening	
4	HIV testing?	
5	Cholesterol / blood sugar screening?	
6	Revision of your existing medication to the most cost effective generic options?	
7	Revision of your existing medication to decrease side effects?	
8	Annual PAP smears with reminders?	
9	Anual monthly BP / urine / blood sugar / cholesterol check-ups with reminders?	
10	Medication / assistance to stop / reduce smoking?	
11	Purchasing a practise approved first aid kit for your car / home?	

O. Would you like to take advantage of the following services? (Tick if 'yes')

1	Blood / test results SMS'd to you by the laboratory?	
2	Info relating to your illness / condition / medication emailed to you by the practise?	
3	X-Ray results relating to your condition SMS'd OR emailed to you?	
4	Courtesy laminated medical history & personal contact emergency info card for your wallet / car	

P. Is there anything else you wish to advise / inform / request of the practise?

Q. Please could you tell us who referred you to us, and how did you hear about the practise?

Thank you for your time!

We look forward to partnering with you in optimising your health, today and in the future.