MJD Health Medical Clinics

ADULT MEDICAL HISTORY

Name: _____ Surname: _____ Date: ____/____/____

Allergies

Do you have any allergies or are you sensitive to drugs or dressings? YES / NO
If yes please specify:

	Reaction

Medical Conditions (past and present)
E.g. Cancer, Heart Disease, Diabetes, Mental Health issues, Stroke, Asthma

Operations (please include the year)

Medications (Current medications including over the counter medications and supplements)

Medication	Strength	How many per day	What time of day

Family Medical History (past and present)
E.g. Cancer, Heart Disease, Diabetes, Mental Health issues, Stroke, Asthma, Eczma

Social History

Alcohol: ☐ Yes ☐ No If yes: How many *days* per week? _____
How many standard drinks are consumed per *day*?_____
Would you have 6 or more drinks in a session? ☐ Yes ☐ No
☐ Never ☐ Weekly ☐Less than Monthly ☐Monthly ☐Daily
Are you concerned about your drinking? ☐Yes ☐No

Smoking ☐ Yes ☐ Never ☐ Ex-smoker - Year stopped:_____
If yes: How many cigarettes per day do you currently smoke:_____
What stage of quitting are you at: ☐ Not ready ☐ Unsure ☐Thinking ☐Recent quitter
Would you like more information about quitting: ☐Yes ☐No
How many times a week do you exercise?_____
Are you an Elite Athlete: ☐Yes ☐No

Vaccinations

Tetanus	Yes / No	Year:	
Influenza	Yes / No	Year:	
Pneumococcal	Yes / No	Year:	

Office User Only
Height: cm Bp: / BSL: (if applicable - at risk, family hx, ?bloods)
Weight: kgs Pulse: Temp: Waist : cm Hip: cm