LITTLE LONDON MEDICAL CLINIC
PATIENT HEALTH HISTORY

Surname: ....

First name: ... (patient stickie)....

DOB: ..../............../.............

PERSONAL HEALTH

Accidents/Injuries..

Operations..

Chronic Illnesses...

Allergies...

Hereditary Diseases..

Known health problems..

Current Medications..

FAMILY HISTORY (especially heart, cholesterol, stroke, diabetes, cancer, asthma, eczema)

Mother's Health

Good ☐

Problem...

Deceased (cause)..

Father's Health

Good ☐

Problem...

Deceased (cause)..................................

Brother's/Sister's Health

Good ☐

Problem..

Deceased (cause)..

Wider Family

Good ☐

Problem..

SMOKING STATUS : Please **tick** the space that applies for those aged 15 and over:

Smoking status is an important factor influencing health.

☐ Never smoked ☐ No longer smoke but in the past smoked daily for more than a year ☐ Currently a smoker

LIFESTYLE

Exercise

Less than 3x weekly ☐

More than 3x weekly ☐

None ☐

Recreational Drugs

No ☐

Past Use ☐

Present Use ☐

Alcohol

Yes ☐ No ☐

How much each week?

....

WOMEN ONLY

Do you use contraceptives? Yes ☐ No ☐

What type?..

Number of pregnancies ....

Any complications?...

Any menstrual problems? ....

When was your last cervical smear? ....

Any abnormal smears?...

Have you had a mammogram? ....

If so, when...

PHYSICAL EXAMINATION - Nursing Staff to fill in

Height.................... Weight.................. BP.................... Blood Glucose..................... Waist Circumference.....................

Vaccinations Date of Last tetanus.................................. Date of last flu vaccination....................................

Other:...

Urinalysis Albumen.................. Glucose.................. Blood......................