Merthyr Medical Centre

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Once completed, please hand this multi-page questionnaire directly to your Doctor.

If there are any sections you prefer not to answer, feel free to leave them blank.

Patient name: _____ Age: _____

Which topics do you wish to discuss with your doctor today?

Other:

_____

Which of these is the most important?

_____

Menstrual History:

Age at menarche (first period) _____

Current length of period (days) _____ Heavy? YES / NO

Current length of cycle (eg monthly, every 23 days) _____ Painful? YES / NO

Have you had any bleeding outside of your normal period? YES / NO

Have you had any bleeding after sex? YES / NO

Pregnancies: Please include all pregnancies

Year

Vaginal delivery

Forceps Caesarean Section

Other Outcome – Details (eg miscarriage/termination)

Contraception: Current _____

Past _____

Preventative Health:

When was your last Pap smear taken? _____ Normal / Abnormal

If you have ever had an abnormal Pap smear, please give details:

_____

When was your last Mammogram? _____ Result:

_____

Social History:

Occupation: _____ Marital Status: _____

Relationships:

Heterosexual/Homosexual/Bisexual/Transgender/Other

Smoker / Non Smoker / Ex-Smoker

(Please circle your answer)

Alcohol

Other drug use Type:

Recreational

Exercise:

What type of exercise do you do?

_____

Duration & Frequency of exercise

_____

Relaxation / Stress Management:

Do you practice meditation, yoga, tai chi or other?

_____

Diet:

Do you follow a specific type of diet? YES/NO

If yes, please specify (e.g. vegetarian, gluten free, low fat)

_____

When was your last Bone density scan? _____ Result: _____

When was your last screening test for Bowel Cancer? _____ Result: _____

Past Medical History

Have you suffered from any of the following - Currently or in the past?

Heart attack	Anxiety or depression	Liver disease
Stroke	Glandular Fever	Asthma
Kidney Disease	Blood Clot	Osteoporosis
High blood pressure	Diabetes	Fracture
High cholesterol	Epilepsy	Cancer

Please list current and past serious illnesses, operations, hospital admissions, (if none write Nil)

Year Details-

Current medications:

Please include ALL tablets, inhalers, patches, gels or injections – As well as the pill and any ‘natural’ remedies such as vitamins, herbal remedies, homeopathic remedies & supplements.

Allergies:

Do you have any allergies – in particular to medications?

Allergy Reaction

Family History:

Has anyone in your close family suffered from the following?

(Please include the Relative affected eg: Mother, Sister etc)

Disease Relative Affected Disease Relative affected

Heart attack	Bowel cancer	High blood pressure
	Stroke	Cancer of the cervix/uterus
Ovarian cancer	Breast Cancer	Any other cancer
Blood clot(s)	Thyroid disease	Arthritis
Diabetes	Depression	Schizophrenia
Osteoporosis		

Other:

Thank you for completing the questionnaire. Please hand directly to your Doctor.