Livingstone Street Clinic

NEW PATIENT MEDICAL INFORMATION FORM
PLEASE HAND TO THE DOCTOR

SURNAME: _____ **FIRST NAME:** _____

DATE OF BIRTH: _____

ALLERGIES: to Antibiotics/Medications and reactions – please list.

_____

HEIGHT _____ **WEIGHT** _____ **WAIST**_____

LIST KNOWN MEDICAL CONDITIONS: _____

FAMILY HISTORY: _____

List Current Medications and dose:

_____
_____
_____
_____

SMOKING:

□ Never smoked □ Current smoker Frequency: □ Daily □ Less than weekly □ Weekly

Number of cigarettes per day: _____ Year commenced smoking: _____

□ Ex- smoker Quit date / / Number of cigarettes per day: _____

ALCOHOL CONSUMPTION: ***Days a week you usually drink alcohol?***

□ Never (Non-drinker) □ Less than monthly □ 2-4 times a month

□ 2-3 times a week □ 4 or more times a week

How many standards drinks do you have on a typical day?

□ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 or 9 □ 10 or more

How often do you have 6 or more standard drinks on one occasion?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Are you concerned about your drinking?

□ Yes □ No □ Don't know