Livingstone Street Clinic

NEW PATIENT MEDICAL INFORMATION FORM
PLEASE HAND TO THE DOCTOR

SURNAME:_____**FIRST GIVEN NAME**_____

DATE OF BIRTH: _____

ALLERGIES: to Antibiotics/Medications and reactions

_____

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

KNOWN MEDICAL CONDITIONS _____

FAMILY HISTORY:_____

Current Medications to be discussed with doctor

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