NBCC
Northern Blood and Cancer Care

Medical History Form

Patient Details

Full name _____ Today's date _____

Date of birth _____ Weight _____ Height _____

Reason For Appointment

_____

Medical History

Please tick any of the following conditions that you have been diagnosed with or have experienced in the past:

- ☐ asthma/ chronic obstructive pulmonary disease/ other breathing disorders
- ☐ high blood pressure (hypertension)
- ☐ high cholesterol
- ☐ diabetes (type 1 or type 2)
- ☐ heart disease/ heart attack/ angina
- ☐ irregular heart rhythm
- ☐ stroke/ transient ischemic attack (TIA)
- ☐ migraine
- ☐ anaemia
- ☐ blood clots e.g. deep vein thrombosis (DVT) or pulmonary emboli (PE)
- ☐ cancer (please specify type): _____
- ☐ kidney disease
- ☐ liver disease including hepatitis
- ☐ gastrointestinal disorders e.g. indigestion or reflux, ulcers, inflammatory bowel disease
- ☐ neurological disorders e.g. Parkinson's disease, seizures/ epilepsy
- ☐ mental health disorders e.g. anxiety, depression
- ☐ thyroid problems
- ☐ eye problems e.g. cataracts, glaucoma, visual impairment
- ☐ arthritis
- ☐ autoimmune disease e.g. lupus, rheumatoid arthritis
- ☐ infectious diseases e.g. HIV, hepatitis, tuberculosis

Surgical History

Please list any surgeries or procedures you have had in the past:

1. _____ Date of surgery/procedure _____
2. _____ Date of surgery/procedure _____
3. _____ Date of surgery/procedure _____

Please email this form and Patient Registration Form to admin@northernbcc.com.au
If this is not possible, please arrive 15 minutes early for your appointment.

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Medications

Are you on aspirin and/ or any blood thinning medication? ☐ Yes ☐ No

Please list all current medications including prescriptions, over-the-counter, and supplements:

Medication name	Strength	Frequency	Reason

Allergies

Do you have any known allergies to medications? ☐ Yes ☐ No

If yes, please list medication and reaction: _____

_____

Do you have any known environmental or food allergies? ☐ Yes ☐ No

If yes, please list: _____

_____

Social History

Tobacco use: ☐ Never ☐ Previously but quit ☐ Current

Alcohol use: ☐ Never ☐ Occasionally ☐ Daily Amount _____

Other drug use: _____

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