DR. ELIZE WETHMAR – PATIENT MEDICAL HISTORY FORM

DATE: _____

PATIENT INFORMATION

SURNAME	
FULL NAME	
BIRTH DATE	
AGE	
MARITAL STATUS	
OCCUPATION	

PATIENT MEDICAL INFORMATION

MEDICAL CONDITION	NO	YES	ADDITIONAL INFORMATION
Heart Disease/High BP			
Lung Disease			
Asthma			
Diabetes			
Thyroid Problems			
Bleeder/Blood Disorder			
Nerve Disease			
Depression			
High Cholesterol			
Medicine Allergies			
Other Allergies			
Cancer			
Unspecified Conditions			

ADDITIONAL INFORMATION

EXTRA INFORMATION	NO	YES	ADDITIONAL INFORMATION
Currently Smoking			If yes, how many per day?
Previous Smoker			If yes, how long ago?
Alcohol Use			If yes, how many glasses per week?
Current Prescription Medication			If yes, please stipulate:
Homeopathic or Over-the-Counter Medication			If yes, please stipulate:
Previous Surgeries			If yes, please stipulate:

GYNAECOLOGICAL INFORMATION

	NO	YES	ADDITIONAL INFORMATION
Contraceptive			If yes, please stipulate:
Normal Menstruation			
Most Recent Mammogram			Date: Result:
Most Recent Pap Smear			Date: Result:
Urine Leakage			If yes, please stipulate when:
Children			If yes, how many? Caesareans: Vaginal Births: Miscarriages:

FAMILY HISTORY

Family Member	Details
Father	
Mother	
Grandparents	
Siblings	
Other	

NEXT OF KIN

NAME: _____

MOBILE: _____

RELATIONSHIP: _____

DECLARATION

I, (Full Name of Patient)_____ hereby declare that the above information I have supplied is true and I am responsible for any false information provided.

SIGNATURE: _____

DATE: _____