New Patient Details & History

Surname & Full names: _____

Name known by: _____ Male ____ Female: ____

Date of birth: _____ Current Age _____

Own Birth: Natural: (___) / Cesarean Section: (___) Breastfed: (No) / (Yes) _____ (Months)

Females: Times Pregnant: ____ Live born children: ____ Miscarriages: ____

Females: Contraception used: Yes: _____ / No: _____. Type: _____

Marital Status: _____ Occupation: _____

Hobbies: _____

Blood Group: _____

Family History & Birth.

Diseases occurring often in Father's family: _____

_____

_____

Father's Health (if still alive) or cause of death and at what age? _____

_____

_____

Diseases occurring often in Mother's family: _____

_____

_____

Mother's Health (if still alive) or cause of death and at what age? _____

_____

_____

Problems with your mother's health or your health during the pregnancy. _____

_____

_____

Problems during the birth process. _____

_____

_____

Number of Siblings (Brothers & Sisters): _____

Status of health of siblings: Current Age:

Previous Surgery:

Procedure: Year:

Allergies: _____

Important events that lead to deterioration in health: _____

Physical Activity:

Type Times a Week Duration

Chronic conditions already diagnosed & any medication <u>currently</u> taken for the condition:

Year Diagnosed: Condition: Medicine/s taken & Dosage:

Sources of Water:

Main Source: Tap ___ / Bottle ___ / Filter ___ Filter brand name _____

Alternative Source: Tap ___ / Bottle ___ / Filter ___ Brand name _____

Bowel Movement:

Current frequency of bowel movement: _____ per day / _____ per week.

Stools: Normal: _____ Hard: _____ Loose: _____

Current complaints in order of priority:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____