uniCare
MEDICAL CENTRE

HEALTH HISTORY QUESTIONNAIRE

In order to allow us to provide you with the best possible care, we would like to know about your health history. Information you provide is strictly confidential and will not be released to anyone without your knowledge and consent.

PERSONAL INFORMATION

Name (First, Middle, Last) Date of Birth

Gender Male Female Nationality Marital Status

Employer Designation

Address Telephone No.

MEDICATIONS

List all prescription and over the counter medications, vitamins or alternative medications you take on a regular basis

Name of Medication	Dose & Frequency	Since when (months/years)

ALLERGIES

Please give details of medicines or foods that have ever caused an allergy or a reaction. Describe reaction

IMMUNISATIONS

Have you ever had immunizations for following infections – indicate date of vaccination

Name of Vaccination	Primary dose (childhood) month/year	Booster dose (month/year)
Tetanus/Diphtheria/Pertussis		
Measles/mumps/Rubella		
Hepatitis A		
Hepatitis B		
Typhoid		
Chicken pox		
Influenza		
Other (mention name & Date)		

HEALTH HABITS

Exercise Regular Less than once a week Less than once a month Never

What exercise do you do

Do you consume alcohol Yes No

If yes Type Quantity Days per week

Do you smoke Yes No Ex Smoker Years smoked Stopped When

Are you on any special diet Yes No

If yes please describe

FAMILY HISTORY

Has anyone in your family had Tuberculosis, Cancer, High blood pressure, heart disease, stroke, epilepsy, kidney disease, Diabetes/ other endocrine diseases, arthritis, mental illness or any other significant medical problem – please describe

Father Age if Living Present Health

Age at Death Cause of Death

Mother Age if Living Present Health

Age at Death Cause of Death

Brothers & Sisters – please mention any significant medical problems

WOMEN

Date of first period Year When was your last period dd/mm/yyyy

Number of pregnancies Miscarriages/abortions Living children

Any sexual difficulties
or gynecological symptoms

MEN

Date of last testicular exam mm/yyyy When was your last prostate exam mm/yyyy

Describe any erectile or
sexual dysfunction

CURRENT HEALTH HISTORY

Have you ever been treated for or had any known indication of:

Check applicable items	No	Yes	Please give details (use additional comments space below if necessary)
Disease or disorder of ears, nose or throat			
Vision or Eye disorders/ do you wear glasses or lenses			
Frequent headaches or migraine			
Convulsions or epilepsy			
Dizziness, numbness, blackout or change in memory			
Trouble talking, walking or weakness of limbs			
Tuberculosis			
Cough shortness of breath, emphysema or bronchitis			
Pneumonia, pleurisy or other lung disease			
Asthma or other allergy			
Heart disease or heart murmurs			
Rheumatic Fever			
Chest pain or palpitations			
Swelling of the feet, leg cramps or varicose veins			
Difficulty swallowing, nausea or vomiting			
Indigestion, heartburn or peptic ulcer			
Gas, abdominal pain, constipation or diarrhea			
Frequent or painful urination			
Trouble controlling urine			
Sexually transmitted disease			
Diabetes or high sugar levels			

Thyroid or other endocrine diseases

Chronic back pain, neck pain

Sciatica or slipped disc

Joint pain or stiffness

Muscle pain or weakness

Skin disease

Tropical diseases like malaria, typhoid, jaundice

Lump, pain or discharge from the breasts

Depressed mood or crying

Stress or anxiety

Surgical operations

Injuries

Any illness not mentioned above

Any general checks or tests done recently

Additional comments