



# Medical Systems Review

Name: \_\_\_\_\_

Please tick the problems that you have or have had in the past:

## **BRAIN/ NERVOUS SYSTEM**

Stroke  TIA  Epilepsy  Brain Tumour  Other \_\_\_\_\_

## **HEART**

Heart Attack  Angina  Blood pressure  AF  Other \_\_\_\_\_

## **LUNGS**

Asthma  Pneumonia  Bronchitis  Other \_\_\_\_\_

## **GASTROINTESTINAL**

Stomach Ulcer  Acid Reflux  Cancer  Other \_\_\_\_\_

## **KIDNEY/ URINARY SYSTEM**

Prostate problems  Kidney/ Bladder stones  Other \_\_\_\_\_

## **ENDOCRINE/ MUSCULOSKELETAL/ IMMUNOLOGICAL SYSTEM**

Diabetes  Rheumatoid Arthritis  Osteoarthritis  Other \_\_\_\_\_

## **HAEMATOLOGICAL**

Bleeding disorders  Leukaemia  Other \_\_\_\_\_

## **HEPATITIS/ HIV**

Hepatitis C  HIV  Other Infectious diseases \_\_\_\_\_

**SMOKER** packets \_\_\_\_/\_\_\_\_ years **ALCOHOL** average drinks/day \_\_\_\_

**CAFFIENE** average drinks/day \_\_\_\_

## **CURRENT MEDICATIONS**

Aspirin  Warfarin  Non steroidal Antiinflammatory  Prednisone

Other medications \_\_\_\_\_

Please note that this office maintains all your records according to the Privacy Act 2001.