Comprehensive Health Assessment

Confidential Medical History

This questionnaire should take around 10 minutes to complete. Please take it with you to your appointment to discuss confidentially with your treating doctor. This is not to be submitted to MIGA.

Personal Details

Surname:

First name: Middle name:

DOB: / /

Past History

Medical	
Surgical	
Psychiatric	
Hospitalisations	
Infectious diseases	
Needle-stick injury	

Specifically, do you have:

Condition	Treated	Controlled	Result
Hypertension			
Hyperlipidaemia			
Hyperglycaemia			
Cancer – type			
Hepatitis B or C			

Social History

Indicate in the table below which you regard as your most significant **PERSONAL** supports:

Individuals	Yes/No	
Spouse/Relationship partner	Yes	No
Extended family	Yes	No
Medical colleagues	Yes	No
Non-medical colleagues	Yes	No
Community club members	Yes	No
Employer	Yes	No
Church	Yes	No
Professional (e.g. accountant, lawyer)	Yes	No
Other	Yes	No

Family History

Complete the following family history with **age** at diagnosis

	Father	Mother	Sister	Brother	Grandparent	Aunt/Uncle	Offspring
Cancer - Type							
Diabetes - Type							
CVD - Premature							
Stroke							
TB							
Autoimmune							
GI polyps							
Dementia- early							
Depression							
Suicide							
Mental illness							
Other							

Medication

Prescription drugs and dosage	Prescriber (indicate if self)
1.	
2.	
3.	
OTC	
1.	
2.	
Herbal	
1.	
2.	

Allergies and Sensitivities

Pharmaceutical	Reaction
Dietary	**Reaction**
Environmental	**Reaction**

Substances

It is important to feel free to discuss your personal use of any of the following and any concerns you may have with your treating doctor.

Substance	Current or past use?	Are you concerned?
Tobacco		Yes No
THC		Yes No
Benzodiazepines		Yes No
Alcohol		Yes No
Illicit drugs		Yes No

Systems Review

Do you have any current health concerns in **any** of the following organs or systems? Briefly detail.

System	Brief description
Skin	
Eyes	
ENT	
Breasts	
Cardiovascular	
Reproductive organs	
Sexual health	
Infectious disease	
Cognition or memory	
Musculoskeletal	
Respiratory	
Neurological	

Other specific areas of concern/symptoms

Are you concerned that you are experiencing any of the following? (Please tick)

Stress		Unexpected weight loss		Workplace harassment	
Depression		Night sweats		Career crisis/Retirement	
Anxiety		Fatigue		Relationship difficulty	
Thoughts of suicide		Memory loss		Domestic violence	

Medico-legal matters

This is a very significant stressor for doctors.

Are you currently the subject of a complaint or claim?

Have you ever been?

If so, when?

Have you ever suffered a health consequence as a result of a medico-legal matter?

Lifestyle

Nutrition: The nutritional status of medical professionals can be suboptimal.

Do you have concerns around and of the following? (Please tick)

Loss of appetite		Lactose		Meal quality		Cholesterol	
Iron		Gluten		Meal frequency		Overweight	
Vit D		Food allergy		Bulimia/binge eating		Underweight	

Exercise: Describe your current exercise routine:

Type	
Frequency (x/week)	
Intensity (low, med, high)	

Health Screening

Indicate **if** and **when** you have undergone any of the following screening tests:

Test	Yes/No		When
Pap smear	Yes	No	
Breast check	Yes	No	
Skin check	Yes	No	
Digital rectal examination	Yes	No	
PSA	Yes	No	
Cholesterol	Yes	No	
Blood sugar	Yes	No	
Blood pressure	Yes	No	
Faecal occult Hb	Yes	No	
Glaucoma screen	Yes	No	
Audiogram	Yes	No	
Chest X-ray	Yes	No	
STD screens	Yes	No	
MBA20	Yes	No	
FBE	Yes	No	
TFTs	Yes	No	

Immunisation status

Doctors can be under-immunised. Please indicate your current immunisation status on the chart:

Type	Yes/No		Year
Tetanus	Yes	No	
Polio	Yes	No	
Diphtheria	Yes	No	
Mumps	Yes	No	
Measles	Yes	No	
TB	Yes	No	
Influenza	Yes	No	
Swine flu	Yes	No	
Hep A	Yes	No	
Hep B	Yes	No	
Typhoid	Yes	No	
Other	Yes	No	

Relationships

Do you have any concerns about your relationships with your:

- Family?
- Friends?
- Work colleagues?

Your current health and future concerns

Please indicate your main **current** health concerns:

1.
2.
3.

Please indicate your concerns or worries about your **future** health:

1.
2.
3.

Expectations

What do you hope to achieve from this check-up?

How to contact Us

General Enquiries and Client Service

National Free Call 1800 777 156
National Facsimile 1800 839 284

Claims and Legal Services

(during office hours and for 24hr emergency legal support)
National Free Call 1800 839 280
National Facsimile 1800 839 281

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