



PRIVATE & CONFIDENTIAL PATIENT INFORMATION AND HEALTH HISTORY

We are committed to providing our patients with the best care, and to do this it is essential that your medical records are up to date and accurate.

Please assist us by completing the following and handing it directly to your doctor.

(Please only complete the parts of the form you are comfortable with).

Mr. Mrs. Ms. Dr.

Name _____

Age _____

Marital Status _____

Occupation _____

Are you of Aboriginal or Torres Strait Islander origin?

YES NO

Other Cultural Background? _____

Please Identify: _____



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Do you have any drug or other allergies that you are aware of?

Yes No

If yes, please list the allergy and reaction _____

Do You Smoke?

Yes No

If yes, how many per day _____

If you previously smoked and have now quit, when did this occur? _____

Do you drink Alcohol?

Yes No

If yes, how many standard drinks per day? _____

Do you have a history of any serious illness or disease?

Yes No

Please list and include operations: _____

Please list your Current Regular Medications: _____

Do you have a family history of any serious illness or disease?

Yes No

(Asthma, Bowel Cancer, Heart Disease, Breast Cancer, Prostate Cancer, Diabetes)

If so, name the illness and family relationship to you _____

List of Immunisations and approx date/year (if known) _____

Females: When did you last have?

Pap smear _____	not sure <input type="checkbox"/>	never <input type="checkbox"/>
Breast Check _____	not sure <input type="checkbox"/>	never <input type="checkbox"/>
Skin Check _____	not sure <input type="checkbox"/>	never <input type="checkbox"/>

Males: When did you last have?

An overall check up _____	not sure <input type="checkbox"/>	never <input type="checkbox"/>
Skin Check _____	not sure <input type="checkbox"/>	Never <input type="checkbox"/>

Many Thanks, Please Give to the Doctor