KEY MEDICAL INFORMATION

PATIENT NAME: **PATIENT D.O.B**

OCCUPATION:

Please list current medications including vitamins and herbal medicines

_____

Please list any allergies _____

Please list any medical history and past surgery/operations /previous illnesses/injuries

_____

IMMUNISATIONS (please tick relevant boxes)

☐ Pneumococcal (pneumonia) ☐ Influenza ☐ Tetanus
☐ Childhood vaccines up to date ☐ Other (please specify)

_____

_____

GENDER RELATED HEALTH HISTORY

Women's Health (specify approx month/year)

Last pap smear .....

Last mammogram (if aged over 50).....

Men's Health

☐ Last prostate check (if aged 40 +)

LIFESTYLE HEALTH HISTORY

Smoking history (please tick box)
☐ Never
☐ Former smoker – quit date
☐ Current smoker - /day
Number of years smoking

ALCOHOL
☐ Non-drinker
☐ Rarely/light
☐ Moderate
☐ Heavy

Please list any other recreational drug use. Please note your answers will remain confidential:

_____

FAMILY HISTORY

If yes to cancer please specify what kind:_____

Have you ever had or family history of *(please circle if filling in by hand or click on button if filling in electronically)*

Diabetes	☐ Mum	☐ Dad	☐ Sibiling	☐Grandparent	☐Other
Heart disease	☐ Mum	☐ Dad	☐ Sibiling	☐Grandparent	☐Other
Stroke	☐ Mum	☐ Dad	☐ Sibiling	☐Grandparent	☐Other
Asthma	☐ Mum	☐ Dad	☐ Sibiling	☐Grandparent	☐Other
Cancer	☐ Mum	☐ Dad	☐ Sibiling	☐Grandparent	☐Other

CONSENT

☐ **I consent to the use of my personal health information by the Noosa General Practice and other health providers involved in my medical treatment and health care.**

☐ **I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment**

Signature _____ **Date** / /