



Patient Registration: Medical Information Form

Title: _____ Full Name: _____

Date of Birth: _____

Gender: Male / Female / Other

Family History

Do you have a family history of any of the following?

Family member (e.g. Mother, Father, Sister, Brother etc.)

- | | |
|--|-----------------|
| <input type="checkbox"/> Bowel Cancer | Relative: _____ |
| <input type="checkbox"/> Breast Cancer | Relative: _____ |
| <input type="checkbox"/> Prostate Cancer | Relative: _____ |
| <input type="checkbox"/> Blood Pressure High / Low | Relative: _____ |
| <input type="checkbox"/> Cholesterol High / Low | Relative: _____ |
| <input type="checkbox"/> Diabetes Type 1 / Type 2 | Relative: _____ |
| <input type="checkbox"/> Heart Disease Stroke / Heart Attack | Relative: _____ |
| <input type="checkbox"/> Asthma | Relative: _____ |
| <input type="checkbox"/> Other: _____ | Relative: _____ |

Current / Past Illness (Operation / Serious Illness)

- Cancer Bowel / Prostate / Breast / Lung / Skin / _____
- Blood Pressure High / Low
- Cholesterol High / Low
- Diabetes Type 1 / Type 2
- Heart Disease Stroke / Heart Attack
- Osteoarthritis / Osteoporosis
- Asthma
- Previous Operations _____
- Other _____

Allergies

Reaction

- | | |
|---|---|
| <input type="checkbox"/> No Known Allergies | |
| <input type="checkbox"/> Penicillin | Rash / Coughing / Sweats / Vomiting / _____ |
| <input type="checkbox"/> Codeine | Rash / Coughing / Sweats / Vomiting / _____ |
| <input type="checkbox"/> Other Medication _____ | Rash / Coughing / Sweats / Vomiting / _____ |
| <input type="checkbox"/> Peanut | Rash / Coughing / Sweats / Vomiting / _____ |
| <input type="checkbox"/> Other _____ | Rash / Coughing / Sweats / Vomiting / _____ |

SOCIAL HISTORY

Occupation: _____ Retirement date: _____

Marital Status: *Single* ___ *Married* ___ *Separated* ___ *Divorced* ___ *Widowed* ___ *Other* _____

Does the patient have any children? Yes / No How many: _____

Is the patient an "Elite Athlete": Yes / No

Live with: Spouse / Relatives / Friend / Alone

Are you a carer for someone? Yes / No

Do you have a carer? Yes / No / Self

Carer's Name: _____ Carer's Relationship to you: _____

Do you wish to identify yourself as belonging to a specific religious group?



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<u>SMOKING HISTORY</u>	<u>ALCOHOL HISTORY</u>
Non Smoker / Ex-Smoker / Smoker Cigarettes / Cigar / Pipe Year Started _____ Number per day _____ Year Stopped _____ Please circle Status Not ready to quit / Ready to Quit / Attempted to quit / Quit	Non Drinker / Occasional / Moderate / Heavy Year Started _____ Year Stopped _____ Days per week _____ Standard Drinks per day _____

Current Medications

Please list all your current regular medications (including non-prescription e.g. fish oil capsules)

Name	Dose	How often

Information entered into Patient's History	(signed) Dr. Date:
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