Ilam Medical Centre
HEALTH MATTERS

PATIENT CLINICAL INFORMATION UPDATE

Family Name:
Given Names:
Street:
Suburb:
City:
Work Phone:
Cell Phone:
Contact in case of emergency:
Name:
Address
Cell phone number:

NHI:
DOB:
Gender:
Sex at Birth:
GMS:
High Use:
Home Phone:

Other phone number:

Please answer the following questions as well as you are able from memory. We will use your medical files to check dates and obtain further information.

Are you taking any Medications? (please circle) Yes / No
Please list current medication with dosage/attach a list of medications:

Do you have any Allergies to medication? (please circle) Yes / No
If yes, please list allergies AND reaction:

What is your Current Occupation?

What is your Living Situation?

Level of Exercise (please circle): Nil 0-1 hr/wk 1-2 2-3 > 3

Smoking status (please circle): Non-smoker Ex-smoker Current smoker: no. per day ____

Vaping status (please circle): Non-vaper Ex-vaper Current vaper: pods per week _____

Alcohol intake (please circle): nil 0-5 drinks/wk 5-10 10-20 20-30 > 30

Recreational Drug Use (please circle): nil use occasional use frequent use

Personal Medical History (please circle):

Stroke Heart attack High blood pressure Diabetes Asthma Emphysema/Bronchitis

Bowel cancer Breast cancer Cancer (other: _____) Arthritis Rheumatic fever

Hepatitis/liver problem Kidney/bladder problem

Abdominal surgery Orthopaedic surgery (joints and bones) Gynaecological surgery or disorder

Other significant medical problems:

Family medical history (please circle):

Father: Stroke, heart attack, high cholesterol, blood pressure, diabetes, cancer of prostate, cancer of bowel, mental health

Mother: Stroke, heart attack, high cholesterol, blood pressure, diabetes, cancer of breast, cancer of bowel, mental health

Siblings: Stroke, heart attack, high cholesterol, blood pressure, diabetes, cancer of prostate / bowel / breast, mental health

Other significant family health issues:

Do you have a disability? (please circle) Yes / No
If yes, please specify:
E.g. Hard of hearing, visual impairment, mobility difficulty

Do you have any cultural or religious beliefs which may be important to your care?
(eg, Jehovah's Witness) Yes / No
please specify:

Female patients only:
When did you last have a cervical smear taken? ..... N/A

When did you last have a mammogram? ..... N/A

Male patients only:
When did you have your last digital rectal exam? ..... N/A

Disclosing of Information:
Do you have an EPOA in place? Yes / No
If yes, please advise of name, contact details, and provide evidence of activation.
Name:
Contact:

Would you be interested in developing an advanced care plan? Yes / No

Do you consent to anyone else having access to your medical records? Yes / No
If yes, please specify who:

Thank you for your time!