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:
Other phone number:

NHI:
DOB:
Sex at birth:
GMS:
High Use:
Home Phone:

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:

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

What is your Current Occupation?

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 ____

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

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, blood pressure, diabetes, cancer of prostate / bowel

Mother: Stroke, heart attack, blood pressure, diabetes, cancer of bowel / breast

Siblings: Stroke, heart attack, blood pressure, diabetes, cancer of prostate / bowel / breast

Other significant family health issues:

Do you have a disability? (please circle) Yes No
If yes, please specify:

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

Thank you for your time