

Name: _____ DOB: _____ / _____ / _____

1. Do you have any, or have had any of the following medical problems?, or is there a family history of the following:

	Self	Family		Self	Family
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Blood clot	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart Attack <60yr >60yr	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other lung or respiratory disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Kidney disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Other cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Liver disease or Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Bowel disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Joint disease or problems, arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tuberculosis (TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Depression and/or anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other mental health illnesses	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

2. Do you have any **other health, disability problems or inherited conditions?** – please list3. Please list any **regular medications** that you take4. Have you had any **operations?** Yes No *If yes, please list and state date/year*5. Are you **allergic** to any medications? Yes No *If yes, please list*6. Do you **smoke?** No Yes *If yes, how many / day _____*
If Yes - would you like help to **quit smoking** Yes NoHave you ever smoked No Yes *If yes, how much and for how long _____*
*when did you give up _____*7. Do you drink **alcohol?** No Yes *If yes, on average, how much / day _____*8. Do you have any **substance abuse** problems? Yes No9. **Women:** (those over 20 years & sexually active)

When was your most recent cervical smear? _____

Have you ever had an abnormal smear? Yes No Don't knowHave you had a mammogram (those over 40 years)? No Yes *If Yes, when? _____*10. When was your last **Tetanus booster?** _____

Signed: _____

Date: _____

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this. **Please be careful to disclose all important medical/surgical/psychiatric information.**