|  |  |
| --- | --- |
| **Patient’s name:** | **DOB** |

**Medical Information**

The following is a detailed look at your medical history. This information forms the basis of all summaries that may be used, for example to send information to hospitals and other health professionals. It is important that you may supply information that is accurate and detailed for your own benefit.

**Please fill this document to the best of your knowledge. Leave blank if it’s not applicable.**

|  |  |
| --- | --- |
| Allergy | Type of reaction |
|  |  |
|  |  |

**Please list any complimentary therapies that you use, including vitamin & Mineral supplements**

|  |  |  |
| --- | --- | --- |
| Supplement | Dose | How often |
|  |  |  |
|  |  |  |

**Personal History Have you ever suffered from any of the following (please tick)?**

Hepatitis B Tuberculosis  HIV  Hepatitis C

**Family History**

**Does anyone in your family suffer from the following (Please Circle)**

|  |  |  |  |
| --- | --- | --- | --- |
| Diabetes | No | Yes | Who? |
| Heart Disease | No | Yes | Who? |
| Asthma | No | Yes | Who? |
| Cancer | No | Yes | Who?  Type?  Have they survived? |
| Mental Illness, Depression, anxiety, and stress | No | Yes | Who? |
| Any Other Hereditary disease EG. Parkinson’s |  |  |  |
| Other |  |  |  |

Social history

Country of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If outside of Australia, can you speak English? Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| Where do you live | House | Unit | Other |
| Do You Live Alone | No | Yes | With whom? |
| Do You have any services come to your home | No | Yes |  |

What is the Highest level of education you have achieved?

High School Tertiary Education University Other

Please Circle

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do You Smoke | No | Yes  How Many per day? | When did you start | When did you stop |
| Alcohol consumption | No | Yes | If yes how many standard drinks in an average week? |  |
| Do you ever drink more then 6 std drinks on one occasion | No | Yes |  |  |
| Are you concerned about your alcohol consumption | No | Yes |  |  |
| Do You or have you ever used recreational substances | No | Yes | If so, what? | How Much?  How Often? |
| Have you ever required drug or alcohol rehabilitation? | No | Yes |  |  |
| Do You Exercise | No | Yes | How Often? Moderately | How often?  Vigorously |

**History of procedures / operation / illnesses**

Have you ever broken any bones?  yes  No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any disabilities?

Are you Heterosexual?  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Illness, procedures/operations | Date |
|  |  |
|  |  |
|  |  |

In What year were you vaccinated for the following

|  |  |
| --- | --- |
| Tetanus | Year? |
| Hepatitis B | Year? |
| Influenza | Year? |
| Pneumococcal Disease | Year? |
| Whooping Cough | Year? |
| Covid-19 vaccine | Year? |

Who is your GP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is advised to have a nominated GP, but you may need to see other Doctors when yours is not available.

Are you currently being treated by any other doctors outside KRS other than a specialist?

If yes whom?

Have you ever come into contact with radiation, asbestos, lead, fumes, excessive noise, or chemicals in the workplace ?  Yes No

Have you ever had a blood transfusion? Yes No

Date of last

|  |  |
| --- | --- |
| Pap smear | Year? |
| Mammogram | Year? |
| Prostate check | Year? |
| Last Pathology |  |

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_