PATIENT MEDICAL INFORMATION FORM

Patient Name:	Signature

Medical & Family History

Please documents any allergies/adverse reactions and the nature of the reaction.

Allergy	Nature of reaction	Severity

No Known Allergies ☐

Please document any regular medication, supplements and/or Vitamins you take regularly along with dosages and frequency.

Medications/supplements/Vitamins	Frequency/Dosage

Family & Social History

☐Unknown (E.g. Adopted) ☐No Significant Family History

	Yes	No	Age at death	Cause of death
Mother Alive	☐	☐		
Father Alive	☐	☐		

Significant Family History

Mother	Diabetes ☐	Hypertension ☐	Heart Disease ☐	Stroke ☐
	Colon Cancer ☐	Depression ☐	Breast Cancer ☐	Other
Father	Diabetes ☐	Hypertension ☐	Heart Disease ☐	Stroke ☐
	Colon Cancer ☐	Depression ☐		Other

Social

Marital Status Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed ☐

Sexuality _____ Prefer not to say ☐

Elite Athlete Yes ☐ No ☐

Breast Feeding Yes ☐ No ☐

Advanced Care Directive Yes ☐ No ☐ Enduring Guardian Yes ☐ No ☐

Recreational Activities _____

PATIENT MEDICAL INFORMATION FORM

Accommodation and occupation

Lives: Alone ☐ Partner ☐ Family ☐ Relative ☐ Friend ☐

Has Carer Yes ☐ No ☐ If yes who? _____

Do you feel safe in your own home? Yes ☐ No ☐

Current Occupation	
Past Occupation	
ADF Member	No ☐ Current ☐ Past ☐

Have you ever encountered the following in your workplace

Radiation ☐ Asbestos ☐ Lead ☐ Fumes ☐ Excessive noise ☐ Chemicals ☐

Month and/or year of your last:

Pap smear/cervical screening	
Mammogram	
Prostate Check	
Skin Cancer Check	
Imaging	
Pathology	

Alcohol Consumption **If Not applicable, please tick ☐**

Days per week	
Standard alcohol intake	
Past Alcohol intake	Nil ☐ Occasional ☐ Moderate ☐ Heavy ☐
	Year Started Year Stopped
Recreational substance Use: Past ☐ Current ☐	If yes what type, how often:
Are you concerned about your consumption	

Smoking/Vaping **If Not Applicable, Please Tick ☐**

Current smoking/vaping status	Smoker/Vaping ☐ Ex-Smoker /Ex-Vaping ☐
Past smoking/vaping history	Quantity/day ☐<1 ☐1-9 ☐10-19 ☐20-39 ☐40+ Unknown ☐
	Year Started Year Stopped
Are you concerned about your smoking/vaping ?	

PATIENT MEDICAL INFORMATION FORM

Only to be filled out IF this patient in under the age of 17 at the time of filling out this form

Full Name	
Date Of Birth	
Address	
Medicare card Number	
Contact Number	
Relationship to patient	

For Medicare billing purposes, anyone under the age of 17 must have a head of family appointed to received Medicare rebate from billed consults, please fill the details above for appointed head of family.

IF THE PATIENT IS 14 YEARS AND OVER, PLEASE ASK FOR NEXT OF KIN FORM