Meadowbrook Medical Centre

Patient Health Registration Form

Date: _____/_____/_____

Patient Name: _____ **D.O.B:** _____/_____/_____

Do you have any Allergies to Medications or Other? ☐ Yes ☐ No

_____

_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Defacto

Occupation: _____

Tobacco: Y / N how many _____ day / week Start date _____ or Ceased Smoking date _____

Alcohol: Y / N how many _____ day / week / month How many standard drinks _____

Drug use: Y / N _____ (type and frequency)

Your Health History

Do you have or have you had a history of? **Date & Year if possible**

☐ Operations_____

☐ Asthma_____

☐ Diabetes ☐ Type 1 ☐ Type 2_____

☐ High Blood Pressure_____

☐ Other illness_____

Immunisations

Have you had the following immunisations? **Date & Year if possible**

Tetanus Booster	☐ Yes ☐ No ☐ Don't Know	Date:
Hepatitis B	☐ Yes ☐ No ☐ Don't Know	Date:
MMR (measles, mumps, rubella)	☐ Yes ☐ No ☐ Don't Know	Date:
Influenza	☐ Yes ☐ No ☐ Don't Know	Date:
Pneumococcal	☐ Yes ☐ No ☐ Don't Know	Date:

Current medications & dosage (if known)

(Including over the counter medications, vitamins and minerals):

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Please Turn Over

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Family History

Have any members of your family had the following and if so who: eg. Mother, father etc.
(if you list uncle or grandparents please indicate if they are on your fathers or mothers side)

☐ Diabetes	☐ Ovarian Cancer
☐ Asthma	☐ High Cholesterol
☐ Heart Disease	☐ Depression
☐ Mental illness (please specify)	☐ Breast Cancer
☐ Cancer (please specify)	☐ Kidney Disease
☐ Bowel Cancer	☐ Other

For those 65 years and older:

When was the last time you were immunised?		**Date & year if possible**
Influenza	☐ Yes ☐ No ☐ Don't Know	Date:
Pneumococcal pneumonia	☐ Yes ☐ No ☐ Don't Know	Date:

Females:

Have you had the following?		**Date & Year if possible**
Pap smear	☐ Yes ☐ No ☐ Don't Know	Date:
Mammogram	☐ Yes ☐ No ☐ Don't Know	Date:

Males:

Have you had the following?		**Date & Year if possible**
An overall check up	☐ Yes ☐ No ☐ Don't Know	Date:

Do you want a copy of today's consultation forwarded to your regular GP?

☐ Yes ☐ No

Surgery's Name: _____

Doctor's Name: _____

Address: _____

_____Suburb: _____ Postcode: _____

State: _____ Country: _____

Phone: _____ Fax: _____