Meadowbrook Medical Centre

# Patient Health Registration Form

Date: ____ / ____ / _____ Date of birth: ____ / ____ /_____

Patient name: _____

**Do you have any allergies to medications or other?** ☐ Yes ☐ No

_____

_____

_____

## Social History

**Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ De facto

Occupation: _____

Tobacco: ☐ Yes ☐ No. How many? _____ per: ☐ day ☐ week ☐ month

Start date _____ OR Ceased smoking date: _____

Alcohol: ☐ Yes ☐ No. Standard drinks: _____ per: ☐ day ☐ week ☐ month

Drug use: ☐ Yes ☐ No

Type & frequency: _____

## Your health history

Do you have or have you had a history of: (include date & year if possible)

☐ Operations _____

☐ Asthma _____

☐ Diabetes ☐ Type 1 ☐ Type 2 _____

☐ High blood pressure _____

☐ Other illness _____

## Immunisations

Have you had the following immunisations?

| | | | | |
|---|---|---|---|---|
| Tetanus Booster | ☐ Yes | ☐ No | ☐ Unsure | Date: |
| Hepatitis B | ☐ Yes | ☐ No | ☐ Unsure | Date: |
| MMR (measles, mumps, rubella) | ☐ Yes | ☐ No | ☐ Unsure | Date: |
| Influenza | ☐ Yes | ☐ No | ☐ Unsure | Date: |
| Pneumococcal | ☐ Yes | ☐ No | ☐ Unsure | Date: |

## Current medications and dosage (if known)

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

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

## Family history

Have any members of your family had the following and if so, who? *(e.g. Mother, Father etc. If you list extended family, please indicate if they are on your fathers or mothers side)*

☐ Diabetes _____ ☐ Ovarian Cancer _____

☐ Asthma _____ ☐ High Cholesterol _____

☐ Heart Disease _____ ☐ Depression _____

☐ Breast Cancer _____ ☐ Kidney disease _____

☐ Mental Illness (please specify) _____

☐ Cancer (please specify) _____

☐ Bowel cancer _____ ☐ Other _____

## For those 65 years and older

When was the last time you were immunised?

| | | |
|---|---|---|
| Influenza | ☐Yes ☐No ☐Unsure | Date: |
| Pneumococcal | ☐Yes ☐No ☐Unsure | Date: |

## Females

Have you had the following?

| | | |
|---|---|---|
| Pap smear | ☐Yes ☐No ☐Unsure | Date: |
| Mammogram | ☐Yes ☐No ☐Unsure | Date: |

## Males

Have you had the following?

| | | |
|---|---|---|
| An overall check up | ☐Yes ☐No ☐Unsure | 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: _____