Meadowbrook Medical Centre

Patient Health Registration Form

Date: _____/_____/_____

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

Aboriginal or Torres Strait Islander ☐ Yes ☐ No

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

_____

_____

_____

Social History

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

Advanced Health Directive: ☐ Yes ☐ No Enduring Power of Attorney: ☐ Yes ☐ No

Occupation:

_____

Smoking/Vaping: ☐ Yes ☐ No How many ____ per ☐ day ☐ week

Start date _____ or Ceased Smoking date _____

Alcohol: ☐ Yes ☐ No

How many standard drinks _____ per ☐ day ☐ week ☐ month

Drug use: ☐ Yes ☐ No

_____ (type and frequency)

Your Health History

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

☐ Surgeries_____

☐ Asthma_____

☐ Diabetes ☐ Type 1 ☐ Type 2_____

☐ High Blood Pressure_____

☐ Other illness_____

PLEASE TURN OVER

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Current medications & 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: eg. Mother, father etc.
(if you list uncle or grandparents please indicate if they are on your fathers or mothers side)

- ☐ Diabetes, Family member/s: _____
- ☐ Ovarian cancer, Family member/s:_____
- ☐ Heart disease, Family member/s:_____
- ☐ Hypertension, Family member/s:_____
- ☐ Breast cancer, Family member/s:_____
- ☐ Bowel cancer, Family member/s:_____
- ☐ Mental health conditions *(please specify)*, Famlily member/s: _____

_____

- ☐ Cancer *(please specify)*, Famlily member/s: _____

_____

Screening:

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

Cervical Screening	☐ Yes ☐ No ☐ Don't Know	Date:
Mammogram	☐ Yes ☐ No ☐ Don't Know	Date:
Over 50 Bowel Screening	☐ Yes ☐ No ☐ Don't Know	Date:

Thank you.