Patient Registration: Medical Information Form

Title: _____ Full Name: _____

Date of Birth: Gender: Male / Female / Other

Family History

Do you have a family history of any of the following? Family member (e.g. Mother, Father, Sister, Brother etc.)

- ☐ Bowel Cancer — Relative: _____
- ☐ Breast Cancer — Relative: _____
- ☐ Prostate Cancer — Relative: _____
- ☐ Blood Pressure High / Low — Relative: _____
- ☐ Cholesterol High / Low — Relative: _____
- ☐ Diabetes Type 1 / Type 2 — Relative: _____
- ☐ Heart Disease Stroke / Heart Attack — Relative: _____
- ☐ Asthma — Relative: _____
- ☐ Other: _____ — Relative: _____

Current / Past Illness (Operation / Serious Illness)

- ☐ Cancer Bowel / Prostate / Breast / Lung / Skin / _____
- ☐ Blood Pressure High / Low
- ☐ Cholesterol High / Low
- ☐ Diabetes Type 1 / Type 2
- ☐ Heart Disease Stroke / Heart Attack
- ☐ Osteoarthritis / Osteoporosis
- ☐ Asthma
- ☐ Previous Operations _____
- ☐ Other _____

Allergies	Reaction
☐ No Known Allergies	
☐ Penicillin	Rash / Coughing / Sweats / Vomiting / _____
☐ Codeine	Rash / Coughing / Sweats / Vomiting / _____
☐ Other Medication _____	Rash / Coughing / Sweats / Vomiting / _____
☐ Peanut	Rash / Coughing / Sweats / Vomiting / _____
☐ Other _____	Rash / Coughing / Sweats / Vomiting / _____

SOCIAL HISTORY

Occupation: _____ Retirement date: _____

Marital Status: *Single*____ *Married*____ *Separated*____ *Divorced*____ *Widowed*____ *Other* _____

Does the patient have any children? Yes / No How many: _____

Is the patient an "Elite Athlete": Yes / No

Live with: Spouse / Relatives / Friend / Alone

Are you a carer for someone? Yes / No

Do you have a carer? Yes / No / Self

Carer's Name: _____ Carer's Relationship to you: _____

Do you wish to identify yourself as belonging to a specific religious group? ……..

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SMOKING HISTORY

Non Smoker / Ex-Smoker / Smoker

Cigarettes / Cigar / Pipe

Year Started _____

Number per day _____

Year Stopped _____

Please circle Status

Not ready to quit / Ready to Quit / Attempted to quit / Quit

ALCOHOL HISTORY

Non Drinker / Occasional / Moderate / Heavy

Year Started _____

Year Stopped _____

Days per week _____

Standard Drinks per day _____

Current Medications

Please list all your current regular medications (including non-prescription e.g. fish oil capsules)

Name	Dose	How often

Information entered into Patient's History (signed) Dr. .....

Date: .....