PATIENT MEDICAL DETAILS – Please hand to the Doctor
This information will be entered into your CONFIDENTIAL Health Record

TOTAL HEALTH MEDICAL

Your Name: ..... Date of Birth: .....

Address: .....

Allergies: .....

Current Medications and Doses: .....

.....

If you are female and aged between 25 and 70 years – when was your last Pap Smear?
Less than 2 years ago ☐ Over 5 years ago ☐ Can't remember ☐

Do YOU have any personal history of:		Do you have any FAMILY history of the following: please specify relation eg. mother, uncle etc
High Blood Pressure	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
High Cholesterol	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Emphysema/Bronchitis	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Diabetes	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Asthma	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Depression/Anxiety	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Epilepsy/Fits	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Heart Disease	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Kidney Disease	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Cancer	Yes ☐ No ☐	Yes ☐ No ☐ Family relation: .....
Other (Please specify):		

Past Medical Problems and Operations (please specify year): .....

.....

Are you currently undertaking any alternative treatments *eg Acupuncture:* .....
Are the following immunisations up to date?:
COVID1: Yes ☐ No ☐ COVID 2: Yes ☐ No ☐ BOOSTER (3): Yes ☐ No ☐
Tetanus: Yes ☐ No ☐ Flu: Yes ☐ No ☐ Childhood immunisations: Yes ☐ No ☐
What is your height?: ..... cm What is your weight?: ..... kg

Smoking status

Smoker: ☐ Ex-Smoker: ☐ Date ceased: .....
Smoking Frequency: Smokes Daily: ☐ Less than weekly: ☐ Weekly: ☐ Number of cigarettes: .....
Year commenced smoking: ..... Duration (number of years smoked): .....
Assessment: Not ready to quit: ☐ Unsure – quit in 6 months: ☐ Ready – plan to quit within 1 month: ☐ Recently ceased: ☐
Last quit attempt date: ..... Never/Unknown: ☐ Duration of longest period of abstinence: ..... days/weeks/months/years

Alcohol status

How often do you drink Alcohol?:
Never: ☐ 2-3 times a week: ☐ 4 or more times a week: ☐ 2-4 times a month: ☐ Monthly or less: ☐
How many standard drinks containing Alcohol do you have on a typical day?:
1-2: ☐ 3-4: ☐ 6-6: ☐ 7-9: ☐ 10 or more: ☐
How often do you have 6 or more drinks on one occasion?:
Never: ☐ Daily or almost daily: ☐ Weekly: ☐ Less than Monthly: ☐ Monthly: ☐
Patient concerned about drinking: Yes: ☐ No: ☐ Don't Know: ☐