citymedical & skinclinic

Patient Health Information Summary Sheet

Name:.. Date of Birth: ....
Address: ....
Phone: (H):..................................(W)..(M)..
Email: ....
Birth Sex:..Gender Identity: ....

Emergency Contact: (It is essential we have this information)
Name:..Relationship:..
Phone: (H):..................................(W)..(M)..

Next of Kin:
Name:..Relationship:..
Phone: (H):..................................(W)..(M)..

To assist with health initiatives:
Are you of Aboriginal and/or Torres Strait Islander Origin? Yes No
Or another cultural background? Yes No

Details: ....

Who is/was your regular GP? ....
Address: ....
Phone:...

Do you have any allergies or are you sensitive to drugs or dressings? Yes No
If yes, please give details:...
....

Social History/Risk Factors:
Do you:
Smoke: Yes No Number per day: ....Ceased?..
Drink: Yes No Drinks per day:.......................Drinks per week:..............................
Other drugs: Yes No Details: ....

Physical activity: Daily Weekly Sometimes Never

Do you live alone? Yes No
If No: Who do you live with? Spouse Friend Relative Partner
If Yes: Do you have regular visitors? Daily Weekly Monthly Never

Interests, sports, hobbies:..

Please list any current health issues:

....

....

PLEASE TURN OVER >

For Female Patients:

Pregnancy:

Are you pregnant? Yes No

Are you planning a pregnancy? Yes No

Are you on any Medications? Yes No If yes please list below:

....

....

Do you use any non-prescription or over the counter medications (including vitamins)? Yes No

....

....

Past History: (please tick your answers)

☐ Allergies/Hay fever	☐ Gout	☐ Measles	☐ Sexual/Menstrual Dysfunction
☐ Anaemia	☐ Tetanus	☐ Pneumonia	☐ Headaches/Migraines
☐ Arthritis	☐ Heart Palpitations	☐ Polio	☐ Shortness of Breath
☐ Asthma	☐ Rheumatic Fever	☐ Prostate Disease	☐ Sexually Transmitted Disease
☐ Chest Pain	☐ Hepatitis	☐ Rubella	☐ Diabetes
☐ Depression	☐ Incontinence	☐ Scarlet Fever	☐ Epilepsy

☐ Other...

Past Operations of Note:

.... Year .... Year..................

.... Year .... Year..................

Are there any illnesses running in your family? (please tick your answers)

☐ Heart Disease	☐ Stroke	☐ High Blood Pressure	☐ Osteoporosis
☐ Mental Illness	☐ Kidney Disease	☐ Diabetes	☐ Epilepsy/Convulsions
☐ Glaucoma	☐ Thyroid Disease	☐ Cancer	☐ Other

Details: ....

Immunisations/Vaccinations: (eg. tetanus, flu, pneumonia, travel – please tick your answers)

☐ Tetanus	Date:...........................	☐ Hepatitis A	Date:...........................
☐ Influenza	Date:...........................	☐ Hepatitis B	Date:...........................
☐ Pneumococcal	Date:...........................	☐ Polio	Date:...........................

Children's Immunisations:

If you are completing this form for a child are their immunisations up to date? Yes No

Our practice provides our patients with preventative care and early case detection reminders eg. Immunisations, paps smear, skin checks.

Do you wish to have relevant health reminders sent to you? Yes No

Is there anything else your doctor should be aware of? eg. adverse medicine events, allergies: ....

....

....

Patient *(or Parent/Guardian)* Signature: . . . . Date: . . . .