citymedical

Personal Medical Information

Name:				Date of Birth:	
Immunisations:		**Allergies:**	**Reaction:**		
Childhood	Yes / No / Unsure				
Influenza	Yes / No / Unsure				
Pneumovax	Yes / No / Unsure				
Prevenar 13	Yes / No / Unsure				
Zostavax	Yes / No / Unsure				
Tetanus	Yes / No / Unsure				
Whooping Cough	Yes / No / Unsure				
Covid 19	Yes / No / Unsure				

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

For Female Patients:					
Are you pregnant?	Yes	No	Are you planning a pregnancy?	Yes	No

Medical History:			
Are you on any medications?	Yes	No	

Do you use any non-prescription or over the counter medications (including vitamins)?	Yes	No
If yes, please list:		

Past History: *(please tick your answers)*			
☐ Gout	☐ Allergies/Hayfever	☐ Measles	☐ Sexual/Menstrual Dysfunction
☐ Anaemia	☐ Tetanus	☐ Pneumonia	☐ Headaches/Migraines
☐ Arthritis	☐ Diabetes	☐ Polio	☐ Shortness of Breath
☐ Asthma	☐ Epilepsy	☐ Prostate Disease	☐ Sexually Transmitted Disease
☐ Hepatitis	☐ Chest Pain	☐ Incontinence	☐ Heart Palpitations
☐ Rubella	☐ Depression	☐ Scarlet Fever	☐ Rheumatic Fever
☐ Other *(detail)*			

Past Operations of note: *(please list)*		
	Year:	
	Year:	
	Year:	

Are there any illnesses running in your family? *(please tick your answers)*			
☐ Stroke	☐ Thyroid Disease	☐ Kidney Disease	☐ High Blood Pressure
☐ Cancer	☐ Glaucoma	☐ Mental Illness	☐ Epilepsy/Convulsions
☐ Diabetes	☐ Heart Disease	☐ Osteoporosis	
☐ Other *(detail)*			

Most Recent Routine Screenings:		
Cervical Screening Test (CST)	Yes / No / Unsure	*Date if known:*
Mammogram	Yes / No / Unsure	*Date if known:*
Bowel Cancer Screening	Yes / No / Unsure	*Date if known:*
Cholesterol Check	Yes / No / Unsure	*Date if known:*
Blood Pressure Check	Yes / No / Unsure	*Date if known:*
Asthma Check (If applicable)	Yes / No / Unsure	*Date if known:*
Skin Check	Yes / No / Unsure	*Date if known:*
Diabetes Check	Yes / No / Unsure	*Date if known:*

Complex Care Plans:		
Mental Health Care Plan	Yes / No / Unsure	*Date if known:*
Enhanced Primary Care Plan (EPC)	Yes / No / Unsure	*Date if known:*
Health Assessment	Yes / No / Unsure	*Date if known:*