Health Summary

Family Name _____ **Today's Date** _____

Given Name _____ **Date of Birth** _____

Please circle below

Do you have any **allergies**? If yes, please list the name/s of drugs or dressings & reactions experienced:	Yes	No	Unsure
Do you currently or have you ever had **asthma**? If yes, are you currently using a *preventer* or *inhaler*?	Yes	No	
Do you have **Diabetes**? If yes, Type 1 ☐ or Type 2 ☐	Yes	No	
Do you currently have or have you ever had **high blood pressure**?	Yes	No	
Do you currently have or have you ever had from **high cholesterol**?	Yes	No	Unsure
Do you have **heart disease**? If yes, please list the type/s	Yes	No	Unsure
Do you currently have or have you ever had **mental health condition(s)** eg. Anxiety or depression or other? If yes, please list condition(s)	Yes	No	Unsure
Have you had any **operations**? If yes, please list:	Yes	No	Unsure
Do you currently have or have you ever had any **other medical condition(s)**? If yes, please list:	Yes	No	
Are you currently taking any **medication(s)**? If yes, please list: name, strength, & frequency taken:	Yes	No	
Do you **smoke**? If yes, how many cigarettes per day:	Yes	No	
Are you interested in quitting?	Yes	No	
Ex smokers: If you previously smoked, when did you cease? How many cigarettes did you smoke per day?			
Do you drink **alcohol**? If yes, how many drinks per week?	Yes	No	
Have you ever had **sex**? Have you had sex with men, women or both genders? ☐Men ☐Women ☐Both ☐None	Yes	No	
Do you use any forms of ***contraception***? If yes, what forms of contraception do you use? Do you use contraception **every time** you have sex?	Yes Yes	No No	

FAMILY HISTORY (all to complete) Relationship to you, e.g., mother, father, aunt, uncle, brother, sister		
Do any members of your family currently have or have ever had any of the following conditions?	**Maternal (Mother's side)**	**Paternal (Father's side)**
Diabetes?		
High blood pressure, high cholesterol, heart attack, stroke at an early age? , i.e less than 65 years old		
Cancer of breast, ovary, prostate, bowel If yes, what type(s)?		
Mental Illness		

Female Patients			
Have you previously had a **PAP smear**? If yes, what was the date?	Yes	No	
If you are over 50 years, have you had a **breast X-Ray** or **Mammogram**? If yes, what was the date? / / Was the result normal?	Yes	No	
Male Patients			
If you are over 50 years, have you had a **prostate** examination? If yes, what was the date? Was the result normal?	Yes Yes	No No	
VACCINATIONS (all to complete)			
Have you had your childhood vaccinations?	Yes	No	Unsure
Have you had the cervical cancer vaccinations? (series of 3 shots)	Yes	No	
LIFE EVENTS (all to complete)			
Have you experienced any recent **life changing events**? Eg: relationship break up, death of a family member or friend, moved to a new area. If yes, please list:	Yes	No	
Who are you currently living with? i.e. Family, friends, alone, new housemates, student housing. Where does your family or closest support live?			
Disclosure Optional:			
Do you use **party/street drugs**? If yes, which ones and how often?		Yes	No

All information provided by you to the doctor is private. This sheet will be destroyed following your consultation. ***Please turn over..***

Health Information:

Would you like the Health Service to send you information any of the following health concerns:	Please circle	
All patients		
Depression	Yes	No
Anxiety	Yes	No
Quit smoking	Yes	No
Quit drugs	Yes	No
Quit alcohol	Yes	No
Contraception	Yes	No
Sexually active patients		
Sexual health checks	Yes	No
Females		
Pap Smears	Yes	No
Breast Checks	Yes	No
Mammograms	Yes	No
Males		
Prostate examinations	Yes	No

How would you like to receive this information:

Emailed ☐ Email address:

_____

Posted ☐