DENMARK MEDICAL CENTRE

PERSONAL MEDICAL INFORMATION

Name: _____ Date of Birth: ___/___/____

Signature: _____ Date: _____

List of allergies and intolerances to medications:

_____

_____

Current medications (and doses) inc over the counter medications and vitamins etc:

Illnesses and approximate year:

_____

_____

Operations and approximate year:

_____

_____

Family History – include all known significant problems. ie. Diabetes, Asthma, Cancer, Heart Disease, Mental illness:

Father:

_____

_____

Mother:

_____

_____

Brothers and Sisters:

_____

Grandparents:

_____

Please turn over

Immunisations – Have you had the following immunizations?

Tetanus booster Date_____ ☐ Don't know ☐ Haven't had one

Hepatitis B Date_____ ☐ Don't know ☐ Haven't had one

Hepatitis A Date_____ ☐ Don't know ☐ Haven't had one

Influenza Date_____ ☐ Don't know ☐ Haven't had one

Pneumococcal pneumonia Date_____ ☐ Don't know ☐ Haven't had one

Polio Date_____ ☐ Don't know ☐ Haven't had one

Pertussis (Whooping cough) Date_____ ☐ Don't know ☐ Haven't had one

MMR (Measles, Mumps, Rubella) Date_____☐ Don't know ☐ Haven't had one

Children's Immunisations

– If completing this form for a child - is their immunisation up to date? ☐ Yes ☐ No

Cultural Background

What is your cultural background? – ie. Australian/Chinese

Social History

☐ Tobacco _____ day/week or ceased smoking – date _____

☐ Alcohol _____ day/week

☐ Drug use_____ (type and frequency)

Height: _____ cms Weight: _____kgs

Females:

When did you last have a pap smear? Date: _____ ☐ Not sure ☐ Never

Males:

When did you have an overall check up? Date: _____ ☐ Not sure ☐ Never

Please hand this form to the doctor at your consultation.