PEARCEDALE MEDICAL CENTRE

ADULT CLINICAL INFORMATION

(Please give this sheet to the Doctor or Nurse) As a new patient, completing this form helps us get a detailed overview of your health. This form is confidential and will only be kept in your confidential medical record.

Name: _____ Date of Birth: _____

ALLERGIES TO MEDICATION: _____

REACTION CAUSED: _____

OTHER SIGNIFICAT ALLERGIES (e.g. to nuts, eggs): _____

REACTION CAUSED: _____

Your **current or past health problems** (please circle / tick any relevant known conditions)

Skin Problems	Yes ❑ No ❑	Diabetes/high blood sugar/ gestational diabetes	Yes ❑ No ❑
Leg ulcers	Yes ❑ No ❑	High blood pressure	Yes ❑ No ❑
Vision problems/glaucoma	Yes ❑ No ❑	High cholesterol	Yes ❑ No ❑
Unusual or severe infection / meningitis	Yes ❑ No ❑	Heart disease/chest pain/angina/rheumatic fever	Yes ❑ No ❑
Teeth/gum problems	Yes ❑ No ❑	Liver disease /jaundice/gallstones	Yes ❑ No ❑
Asthma/COPD/breathing problems/chronic cough	Yes ❑ No ❑	Coeliac disease / malabsorption/ Crohns disease / Ulcerative colitis	Yes ❑ No ❑
Bladder/kidney/prostate problems	Yes ❑ No ❑	Stomach ulcers/ reflux/ indigestion	Yes ❑ No ❑
Thyroid problem	Yes ❑ No ❑	Hepatitis C/ HIV – AIDS	Yes ❑ No ❑
Anaemia/low blood count	Yes ❑ No ❑	Head Injury	Yes ❑ No ❑
Chronic pain	Yes ❑ No ❑	Sleep apnoea / sleep disorder	Yes ❑ No ❑
Unexplained weight loss	Yes ❑ No ❑	Seizures / epilepsy	Yes ❑ No ❑
Cancer/lymphoma/ leukaemia	Yes ❑ No ❑	Anxiety / depression	Yes ❑ No ❑
DVT/blood clots/bleeding disorder	Yes ❑ No ❑	Other mental health condition	Yes ❑ No ❑
Arthritis/lupus/autoimmune or connective tissue disease	Yes ❑ No ❑	Stroke / TIA/ other brain or neurological problem	Yes ❑ No ❑
Gynaecological problems or breast lumps	Yes ❑ No ❑	Migraine/ recurrent or severe headache	Yes ❑ No ❑
Hearing loss	Yes ❑ No ❑	Blood transfusion	Yes ❑ No ❑
Operations/surgery (please list)	Yes ❑ No ❑		

Have any **family members** had any of the following?

High blood pressure or high cholesterol	Yes ❑ No ❑	If yes, who?
Heart disease (aged under 65 years)	Yes ❑ No ❑	If yes, who?
Sudden cardiac death (aged under 65 years)	Yes ❑ No ❑	If yes, who?
Stroke	Yes ❑ No ❑	If yes, who?
Diabetes	Yes ❑ No ❑	If yes, who?
Bleeding or blood clotting disorder	Yes ❑ No ❑	If yes, who?
Cancer (incl skin) Type (s):.....	Yes ❑ No ❑	If yes, who?
Hereditary conditions or those detected at birth or that run in the family:	Yes ❑ No ❑	If yes, who?
Anxiety / depression / suicide	Yes ❑ No ❑	If yes, who?
Dementia especially young onset	Yes ❑ No ❑	If yes, who?

PEARCEDALE MEDICAL CENTRE

Social History (please circle most relevant to your current circumstances)

What is your marital status?

Single	Married	Defacto	Separated	Divorced	Widowed

Who do you live with?

Alone	With Family	With Friends

Do you have a carer? Yes ❑ No ❑ Are you are carer? Yes ❑ No ❑

Your occupation(s): _____

PHYSICAL ACTIVITY (Please circle your activity level over the last 4 weeks)

INACTIVE (1)	LIGHT (2)	MODERATE (3)	HEAVY (4)	VERY HEAVY (5)

Do you smoke tobacco? Yes ❑ No ❑ If yes, how many per day? _____

If no, are you an ex-smoker? Yes ❑ No ❑

Do you drink alcohol? Yes ❑ No ❑ If yes, how many days per week? _____

How many standard drinks per day? _____

Do you have any concerns about your alcohol intake? Yes ❑ No ❑

What is your current height and weight (if known) H:_____ W:_____

MEDICATION LIST including over the counter remedies

NAME	STRENGTH	DOSES	REASON

Any other medical information you feel may be relevant:

_____

_____

_____

_____

FOR WOMEN ONLY

Date of last cervical screening test? _____ Any abnormal cervical screening tests in the past? Yes ❑ No ❑

Form of contraception (if any) _____