Jindalee Care
MEDICAL PRACTICE

Patient Medical History Form

15 Years to Adult

PLEASE PROVIDE AN ANSWER TO ALL QUESTIONS

Title: Mr Mrs Ms Miss Dr (please circle one)

FIRST NAME ____________________ **SURNAME** ____________________
First Name

Known as: ____________________ **DOB:** ____ / ____ / ____ **Sex (M/F):** ______
Day Month Year

Occupation: ____________________

ALLERGIES	**Item:** ______ **Reaction:** ______ ______ ______ ______ ______
SOCIAL HISTORY	**Live with:** ______ **Extra Care at Home (eg Home Help, Meals on Wheels):** ______ **Marital Status:** Single Married Defacto Divorced Separated (please circle one) **Sexuality:** Heterosexual Homosexual Bisexual (please circle one)
SMOKING	Never Smoked Ex-Smoker Current Smoker (please circle one) Year Quit ______ Cigarettes per day: ______ Year commenced: ______
ALCOHOL	Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week (please circle) **How many standard drinks on a typical day:** 1 or 2 3 or 4 5 or 6 7 to 9 10 or more **6 or more drinks on one occasion:** Never Less than monthly Monthly Weekly Daiy or almost daily
FAMILY HISTORY	Please list any family medical history: ______ ______ ______
PAST MEDICAL HISTORY	Please list any past medical / surgical history: ______ ______ ______
MEDICATION	Please list current medications: ______ ______ ______

Patients Signature: ____________________ **Date:** ____ / ____ / ____
Day Month Year

We acknowledge that all the above information is confidential under the Privacy Amendment Act 2000 and this will be accessed by Medical Staff Only.