Jindalee Care
MEDICAL PRACTICE

Patient Medical History Form

Infant to 14 Years

PLEASE PROVIDE AN ANSWER TO ALL QUESTIONS

Title: Miss Master (please circle one)

Full Name: _____ (First Name) _____ (Last Name)

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

Lives With: _____

Birth Details Preterm Full Term (please circle one)

FAMILY DETAILS

Parent / Guardian Details:

Name: _____ Phone: _____

Name: _____ Phone: _____

Family History: _____

MEDICAL / BIRTH HISTORY

Please list any medical / birth history: _____

ALLERGIES

Item: _____ **Reaction:** _____

MEDICATION

Please list any current medications: _____

IMMUNISATION

Up to Date Not Immunised Unsure (please circle one)

Location of Immunisations: Australia Overseas (please circle one)

Where Overseas: _____

Extra Vaccinations: _____

COMMENTS

Please list any comments: _____

Parent / Guardian 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.