GRACEMERE MEDICAL CENTRE

PATIENT NAME……. DATE OF BIRTH…….

PATIENT HISTORY

To start your patient chart and your care in the most appropriate way we need your history. Have you had any medical problems, surgical procedures or any other notable events that we need to record, in your life?

This practice actively encourages the use of state and national recall systems for:

PAP SMEARS, DIABETES, IMMUNISATION, CARE PLANNING, HEALTH CHECKS & ASTHMA.

DO YOU WISH TO PARTICIPATE YES NO

ANY KNOWN ALLERGIES……

Heart Disease Yes No
Blood Pressure Yes No
Diabetes Yes No
Epilepsy Yes No
Asthma Yes No
Angina Yes No

Appendix Removed Yes No
Tonsils Removed Yes No
Arthritis Yes No
High Cholesterol Yes No
Stroke Yes No
Other Please List

What **Medications** do you take on a regular basis? …….

…….

Do You Smoke Yes No
Have You Ever Smoked Yes No
Do You Drink Alcohol Yes No
If Yes How Many Days A Week…….. How Much…….

Do You Have A Family History Of Any Of The Following?

Heart Disease Yes No
Depression / Anxiety Yes No
Mental Illness Yes No

Stroke Yes No
Diabetes Yes No
Asthma Yes No

Cancers Yes No

What recreational activities do you do for exercise, relaxation or hobbies? …….

…….....

<u>Nurse to Complete</u>

Height……. Weight……

Blood Pressure ……