Woollahra
Family Medical Practice

PATIENT HEALTH INFORMATION FORM

This information helps the doctor give you the best care. **Please fill in this form and return to receptionist to be entered into your file.**

All information given is confidential.

Name:___________________________________ Date of Birth:_______________________

Known Allergies: ____

Reactivation to Allergies:____

Weight(kgs) (if known): ______________ Height(cm) (if known):_____________________

FAMILY HISTORY

□ Unknown (e.g adopted) □ No significant Family History

Mother alive? □ Yes □ No – Cause of Death ______________________________

Father Alive? □ Yes □ No – Cause of Death ______________________________

Mother: □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Colon Cancer

□ Depression □ Breast Cancer Other:____

Father: □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Colon Cancer

□ Depression Other:____

Other significant Family History: (e.g. Brother – skin cancer) _______________________

____

____

SOCIAL

Marital Status: □ Single □ Married □ De-facto □ Separated □ Divorced

□ Widowed

Sexuality: □ Heterosexual □ Homosexual □ Bisexual □Other:_________________

Elite Athlete: □ Yes □ No

Females only - Pregnant or Breast Feeding: □ Yes □ No

Females only - Are you due for a pap smear: □ Yes □ No

Please turn over and fill in back page

CONFIDENTIAL

Recreational Activities: (e.g tennis/walking)___________________________________

____

Carer: □ Yes Name/ Number:_______________________________________ □ No

Other Social History (e.g children? Who do you live with?)______________________

____

OCCUPATION

Current Occupation: ____

Does/Has your current/previous occupation put you in contact with:

□ Asbestos □ Animals □ Dust □ Radiation

ALCOHOL

□ Non Drinker □ Drinker: Days per week: ______ Standard Drinks Per Day:_______

Past Alcohol Intake: □ None □ Occasional □ Moderate □ Heavy

Are you concerned about your drinking? □ Yes □ No

SMOKING

Smoking: □ Non Smoker □ Ex Smoker □ Smoker - Year Started:____Stopped:___

Smoking Habit: □ Light □ Medium □ Heavy Cigarettes per day:_____

MEDICATION

Please list any medications you are currently taking:

Medication	Reason

Signature:________________________________Date:_______________________

CONFIDENTIAL