NEW PATIENT MEDICAL INFORMATION FORM

PLEASE HAND TO THE DOCTOR

NAME:

DATE OF BIRTH:

OCCUPATION:

SIGNIFICANT PAST HISTORY:
Serious Illness / Operations – please list year

Allergies to antibiotics / medication:

Medications: Name and Dose:

Height: Weight:

FAMILY HISTORY: significant illnesses of close relatives:

IMMUNISATION HISTORY:

Completed childhood immunisation ☐ Yes ☐ No ☐ Unsure

Completed School aged immunisations ☐ Yes ☐ No ☐ Unsure

Adult and travel immunisations details:

SMOKING: ☐ Never smoked

☐ Current smoker Frequency: ☐ Daily ☐ Less than weekly ☐ Weekly

Number of cigarettes per day: Year commenced smoking:

☐ Ex smoker Quit date / / Number of cigarettes per day: Year commenced smoking:

ALCOHOL CONSUMPTION: ***Days a week you usually drink alcohol?***

☐ Never (Non-drinker) ☐ Less than monthly ☐ 2-4 times a month

☐ 2-3 times a week ☐ 4 or more times a week

How many standards drinks do you have on a typical day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 9 ☐ 10 or more

How often do you have 6 or more standard drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Are you concerned about your drinking?

☐ Yes ☐ No

Additional comments on alcohol consumption: