PEARCEDALE
MEDICAL CENTRE

ADULT CLINICAL INFORMATION

(Please give this sheet to the Doctor or Nurse)

As a new patient, completing this form helps us get a detailed overview of your health. This form is confidential and will only be kept in your confidential medical record.

Name: Date of birth:

Your current or past health problems *(circle any relevant known conditions)*

Skin problems	Yes	No	Diabetes/high blood sugar/ gestational diabetes	Yes	No
Leg ulcers	Yes	No	High blood pressure	Yes	No
Vision problems/glaucoma	Yes	No	High cholesterol	Yes	No
Unusual or severe infection/ meningitis	Yes	No	Heart disease/chest pain/ angina/ rheumatic fever	Yes	No
Teeth/gum problems	Yes	No	Liver disease/jaundice/gallstones	Yes	No
Asthma/COPD/breathing problems/ chronic cough	Yes	No	Coeliac disease/malabsorption/ Crohn's disease/Ulcerative colitis	Yes	No
Bladder/kidney/prostate problems	Yes	No	Stomach ulcers/reflux/indigestion	Yes	No
Thyroid problem	Yes	No	Hepatitis C/HIV - AIDS	Yes	No
Anaemia/low blood count	Yes	No	Head injury	Yes	No
Chronic pain	Yes	No	Sleep apnoea/ sleep disorder	Yes	No
Unexplained weight loss	Yes	No	Seizures/epilepsy	Yes	No
Cancer/lymphoma/leukaemia	Yes	No	Anxiety/depression	Yes	No
DVT/blood clots/bleeding disorder	Yes	No	Other mental health condition	Yes	No
Arthritis/ Lupus/autoimmune or connective tissue disease	Yes	No	Stroke/TIA/other brain or neurological problem	Yes	No
Gynaecological problems or breast lumps	Yes	No	Migraine/recurrent or severe headache	Yes	No
Hearing loss	Yes	No	Blood transfusion	Yes	No
Operations/surgery (please list)	Yes	No			

Have any family members had any of the following ?

High blood pressure or high cholesterol	Yes	No	Stroke	Yes	No
Heart disease (aged under 65 years)	Yes	No	Diabetes	Yes	No
Sudden cardiac death (aged under 65)	Yes	No	Bleeding or blood clotting disorder	Yes	No
Cancer (incl skin cancer) Type(s):	Yes	No	Anxiety/depression/suicide	Yes	No
Hereditary conditions or those detected at birth or that run in the family:	Yes	No	Dementia especially young onset	Yes	No

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Some clinical problems are more (or less) likely to occur in people of particular ethnic backgrounds. If you wish us to be aware of your ETHNIC ORIGINS, please record here:

Your OCCUPATION(S):

PHYSICAL ACTIVITY (Please indicate your activity level over the last 4 weeks)

INACTIVE (1)	LIGHT (2)	MODERATE (3)	HEAVY (4)	VERY HEAVY (5)

MEDICATION LIST including over-the-counter remedies

NAME	STRENGTH	DOSES	REASON

ALLERGIES TO MEDICATION:

OTHER SIGNIFICANT ALLERGIES (e.g. to nuts, eggs):

Do you smoke tobacco? Yes No If no, are you an ex-smoker? Yes No

Do you drink alcohol? Yes No

Have you any concerns about your alcohol intake? Yes No

FOR WOMEN: Date of last pap smear?

Any abnormal pap smears in past? Yes No

Form of contraception (if any):

Any other Medical Information you feel may be relevant: