HILLCREST & TAMAHERE MEDICAL CENTRES
PATIENT INFORMATION FORM

Surname:
First Name:
Maiden Name:
Previous Address:

Past history of (Please circle and comment)

Asthma _____ Diabetes _____ Lung disease _____

Migraine _____ Gastric Reflux _____ Allergies _____

Epilepsy _____ Angina/Heart disease _____

Depression _____ High BP _____ Hysterectomy _____

Cancer _____

Chronic Lung Disease / Emphysema _____

List any operations? _____

Anything else? _____

Family history of: (Please circle and state WHO had the condition and WHAT sort and AGE)

Asthma _____ Heart Disease _____ _____

Diabetes _____ Melanoma _____

Cancer _____

Relevant Family History _____

Immunisations

Up to date child immunisations? Yes / No Do you wish to decline any further immunisations? Yes / No

If an adult – last tetanus date _____

If a woman – Have you ever had a smear? Yes / No When? _____

Do you refuse to have smears? Yes / No Have you ever had an abnormal smear? Yes / No

Alcohol Intake (Amount) _____per day / week / month / year What type? _____

Any drug allergies? Yes / No

If so, what allergies? _____

Current Medications_____

_____