CLINICAL INFORMATION FORM

Patients Name: ………………………………………………………………………………………. **Date of Birth**: ……………………………

SECTION A - SOCIAL HISTORY

Smoking Status: ☐ **Non Smoker** ☐ **Smoker** ☐ **Ex-Smoker**

Smoker — How many per day? ______ Year started? ____________

Ex-Smoker — Year started? ______________ Year stopped? _____________

Alcohol Intake: ☐ **Non Drinker** ☐ **Drinker**

How many per day? ______
How many days per week? ____________

Height: _________cm | Weight: ____________kg ☐ **Unsure**

Occupation: ☐ **Retired**

Marital Status: **Single | Married | De-facto | Separated | Divorced | Widowed**

Sexuality: **Heterosexual | Homosexual | Bisexual | Asexual |Trans-gender**

Do you have a Carer? : **Yes | No** If yes, please complete the following details:

Name: ____
Contact Number: ____
Relationship: ____

Are you a Carer? : **Yes | No**

SECTION B - FAMILY MEDICAL HISTORY

Family Medical History: ☐ **Unknown** (eg. Adopted) ☐ **No significant Family History**

Is your: **Mother alive?** ☐ Yes ☐ No Age at death: ______ Cause: ________________________________

Father alive? ☐ Yes ☐ No Age at death: ______ Cause: ________________________________

Significant Family History:

Mother: ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Hypertension (High blood pressure
☐ Colon Cancer ☐ Depression ☐ Breast Cancer

Father: ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Hypertension (High blood pressure)
☐ Colon Cancer ☐ Depression ☐ Breast Cancer

Other (please list all other family members conditions and the relationship to you)**:**

____

____

SECTION C - PERSONAL MEDICAL HISTORY

Do you suffer from any of the following?

☐ Heart Disease ☐ Hypertension ☐ High Cholesterol ☐ Stroke ☐ Diabetes: Type ______
☐ Asthma ☐ Epilepsy ☐ Parkinson's Disease ☐ Arthritis: Type ______________________

Other relevant past medical history:

____
____
____
____
____
____

Do you have any allergies? **Yes | No** If yes, please list below

____
____

Have you had any operations in the past? **Yes | No** If yes, please list below

____
____
____
____
____

WOMEN ONLY:

Have you ever had a pap smear? **Yes | No**

Date of last pap smear? : _________________________ Result: __________________________________

SECTION D – MEDICATIONS

** Please attach list if required

Medication Name	Dose	Frequency