# YOUR HEALTH SUMMARY

(please hand this straight to your doctor)

**Your Name:**_______________________________________________**DOB**_________________

Height: ___________ Weight__________ Blood Type: __________

Please note your birth ethnicity, eg Italian (This helps us provide appropriate \ specific care): _______________

## FAMILY HISTORY:

☐ Unknown (adopted) ☐ No significant family history

Mother alive? ☐ Yes ☐ No Age at death: Cause of death:

Father alive? ☐ Yes ☐ No Age at death: Cause of death:

## SIGNIFICANT FAMILY HISTORY

**Mother** ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke

☐ Colon cancer ☐ Depression ☐ Breast Cancer

**Father** ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke

☐ Colon cancer ☐ Depression ☐ Breast Cancer

## SOCIAL HISTORY (please circle if no tick box)

**Marital Status** Single Married DeFacto Separated Divorced Widowed Other:

**Sexuality:** Asexual Bisexual Gay Heteroxexual Homosexual Lesbian Pansexual Queer Skoliosexual Other

**Accommodation**: Home With relative Other private house Hostel Nursing Home Homeless Rental

Lives with: Spouse Partner Relative Friend Alone

**Elite Athlete**: ☐ Yes ☐ No

Advance Health Directive in place? ☐ Yes ☐ No

Enduring Power of Attorney: ☐ Yes ☐ No (If yes we will need a signed copy to keep on file)

Name: Relationship to patient:

Has Carer: ☐ Yes ☐ No If yes Carer name Carer contact:

Do you feel safe in your own home: ☐ Yes ☐ No

Recreational Activites:

Any other social history:

## ALCOHOL

Current alcohol intake: ☐ Non drinker

Standard drinks per day: Days per week:

or Drinks per week:

Past Alcohol intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Year started: Year stopped:

## TOBACCO

Current smoking history: ☐ Non smoker ☐ Ex Smoker ☐ Smoker ☐ Vaper

(Please circle): Cigarettes Cigars Pipe **Per day**: **Year started**:

Past smoking history:

Quantity per day: under 1 1-9 10-19 20-39 40+

Would you like advice on ceasing smoking? ☐ Yes ☐ No

**Do you have any allergies or sensitivity to drugs or dressings?**

☐ Unsure ☐ No ☐ Yes (If yes please list)

**Do you have any of the following?**

☐ Asthma

☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Gestational Diabetes ☐ Other:

☐ Hypertension? (High blood pressure) ☐ Chronic illness? Eg Heart Disease

☐ Other?

**Have you ever had an operation?** Please list or tell your doctor :

**Immunisations. Have you had the following immunisations?**

Covid Vaccine> How many doses: ☐ Vaccine hesitant

| | | | |
|---|---|---|---|
| Tetanus booster | Year__________ | ☐ Don't Know | ☐ Haven't had one |
| Hepatitis B | Year __________ | ☐ Don't Know | ☐ Haven't had one |
| Hepatitis A | Year __________ | ☐ Don't Know | ☐ Haven't had one |
| Influenza | Year __________ | ☐ Don't Know | ☐ Haven't had one |
| Pneumococcal | Year __________ | ☐ Don't Know | ☐ Haven't had one |
| Polio | Year __________ | ☐ Don't Know | ☐ Haven't had one |

**Children's Immunisations**

***If this form is for a child*** are their immunisations up to date?

☐ Yes ☐ No ☐ Unsure ☐ Parent is a conscientious objector ☐ Child is medically exempt

**Please list any Current Medication (**including over the counter medications, vitamins and minerals):

**Cholesterol:** Checked in the last 12 months? ☐ Yes ☐ No Do you remember the level?

**Blood Pressure:** Checked in the last 12 months**?** ☐ **Yes** ☐ **No**

**Sun Protection:** How often do you protect yourself from the sun when outdoors?

| | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** |
|---|---|---|---|---|---|
| Protective clothing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sunscreen / creams | ☐ | ☐ | ☐ | ☐ | ☐ |

**Females:** When did you last have the following?

Cervical smear Date__________ ☐ not sure ☐ never

**If had elsewhere do you remember which medical centre**? ________________________________________

Breast check Date__________ ☐ not sure ☐ never

Mammogram Date__________ ☐ not sure ☐ never

Skin check Date__________ ☐ not sure ☐ never

Bowel Cancer screening Result:

**Males:** When did you last have a check for the following?

Overall check up Date __________ ☐ not sure ☐ never

Prostate check Date __________ ☐ not sure ☐ never

Skin check Date__________ ☐ not sure ☐ never

Bowel Cancer screening Result:

Do you have any health concerns you would like to receive more information on?

**Your Medical Records at our practice**

If in the future should you require your records to be sent to another practice (or a 3rd party) you must provide written/signed consent from the age of 16 (or earlier if GP deems this appropriate).

Information about our practice: Oppose the recepiton desk is a practice information sheet. This shows all the Gps working here, if any have special interests and information about your rights and our policies.

**You're finished!** Thank you very much, it really helps us ensure your records are up to date.