Good Health
GREENHILLS

Patient Health Information (Please give this page to your GP for entry into your electronic health record)

Name_____ DOB:_____

Allergies

Do you have any allergies? _____

Are you sensitive to any medications or wound dressings? _____

Nature of reaction: _____

Smoking Status

○ Non-smoker ○ Ex-smoker ○ Smoker: Number of cigarettes per day: _____

Drug and Alcohol Consumption

○ Non-drinker ○ Drinker: Number of drinks/day: _____ Number of drinking days/week _____

Do you currently use drugs? ○ No ○ Yes: Drug Type:_____

Exercise

How many days per week do you exercise? ○ 0 ○ 1-2 ○ 3-4 ○ 5+

Community Services

Do you receive any community services, such as Home Care, Meals on Wheels etc?

○ No ○ Yes: _____

Patient Medical History

Please list any significant past medical history including past operations or medical procedures:

_____
_____
_____

Family Medical History

Please list any significant family history of diabetes, asthma, heart disease, high blood pressure, cancer, mental illness or other significant illness:

_____
_____
_____
_____

Current Medications

Please list any current medications, including over-the-counter medications and vitamins/natural supplements you may take:

_____
_____
_____
_____
_____

Vaccinations / Immunisations

Please list your immunisation history (eg. Fluvax March 2012; Hep A vaccine June 2010)

_____
_____
_____

For Women: Date of last pap smear test _____

Thank you for completing this patient data form. Please pass this completed form on to your GP.

Entered into Computer by _____(Doctors initials)