

CLINICAL INFORMATION FORM

Patients Name:

Date of Birth:

SECTION A - SOCIAL HISTORY

Smoking Status: ☐ Non Smoker

☐ Smoker

☐ Ex-Smoker

How many per day? _____

Year started? _____

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**

[illegible]