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**CLINICAL INFORMATION**

***(To be given to Doctor by patient at first consult)***

**First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surname**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any previous illness or medical condition we need to be aware of (tick below)?**

□ High blood pressure □ Angina □ Diabetes

□ Bleeding tendency □ Stomach Ulcer □ Asthma

□ Hepatitis □ Skin cancer surgery □ Varicose Veins

□ Deep vein thrombosis □ Currently pregnant □ HIV

□ Heart valve surgery □ Other – provide relevant details below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies or are you sensitive to drugs or dressings:**

**□ Yes (if yes, please list below) □ No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History**

Have any members of your family had: (please elaborate, eg. Who in your family, what condition)

□ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History -** Do you use any of the following: (list amount where appropriate)

**Tobacco**  □ Never smoked □ Ceased smoking Year Commenced:\_\_\_\_\_\_\_\_\_\_\_\_

 □ Yes. Number \_\_\_\_\_\_\_ day/ \_\_\_\_\_\_ week

**Alcohol** □ No

 □ Yes

 How often do you have a drink containing alcohol:

 □ monthly or less □ 2-4 days/month

□ 2-3 times a week □ 4 or more times a week

 On a day you usually drink alcohol, how many standard drinks do you have?

 □ 1-2 □3-4 □ 5-6 □7-9 □ 10 or more

 How often do you have six or more standard drinks on one occasion?

 □ Never □ Less than monthly □ Monthly □Weekly □Daily

**Drug Use** □ No □ Yes Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_

**Sexuality**

□ Hetrosexual □ Homosexual □ Bisexual

***My Health Record***

**Do you consent to the Practice uploading to My Health Record? YES / NO**