CHARTWELL HEALTH CENTRE
PATIENT INFORMATION FORM

Surname:
First Name:
Maiden Name:
Previous Address:
Occupation:
Employer:
Employer Address:
Employer Phone:

Past history of (Please circle and comment)

Asthma ______________________ Diabetes ______________________ Lung disease ___________________

Migraine _____________________ Gastric Reflux _________________ Allergies ______________________

Epilepsy _____________________ Angina/Heart disease ____

Depression ___________________ High BP ______________________ Hysterectomy ___________________

Cancer ____

List any operations? ____

Anything else? ____

Family history of: (Please circle and state who had the condition and what sort)

Asthma __________________________ Heart Disease _________________________________

Diabetes _________________________ Melanoma ____________________________________

Cancer __________________________ No relevant Family History ______________________

Immunisations

Up to date child immunisations? Yes / No Do you wish to decline any further immunisations? Yes / No

If an adult – last tetanus date _________________

If a woman – Have you ever had a smear? Yes / No When? _____________________

Do you refuse to have smears? Yes / No Have you ever had an abnormal smear? Yes / No

If a woman – Have you ever had a mammogram?Yes / No When? _____________________

Where did you have the mammogram? ____

Do you refuse to have mammogram? Yes / No Have you ever had an abnormal mammogram? Yes / No

Smoker? Never Smoked Current Smoker In the past smoked daily for more than a year but no longer smoke

Alcohol Intake (Amount) _____________per day / week / month / year What type? _________________

Any drug allergies? Yes / No

If so, what allergies? ____

Current Medications____

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