Grace Medical Skin and Vein Centre

Patient Information Form

Medical History/Demographics Form

****Please fill out the following questions regarding your medical history:**

***Name:**_____ ***DOB**_____

Are you under any Medical Specialists? Y ☐ **N** ☐ **If so; who/conditions:** _____

Do you have any allergies? - Medications, non drug or other **(please specify). If nil known allergies, please tick box** ☐

Allergy:	Reaction + severity: mild, moderate or severe	Allergy:	Reaction + severity: mild, moderate or severe

Family History

Mother: Alive / Deceased Age: _____ Cause: _____

Father: Alive / Deceased Age: _____ Cause: _____

Significant other family history:

_____

Medical History: Tick box if you have ever had any of the following:

Respiratory Conditions	✓
Emphysema/Chronic Bronchitis	
Asthma	
Other (specify):	
Cardiac Conditions	
Heart attack	
Angina/chest pain	
Heart failure/CCF	
Abnormal rhythms (specify):	
High blood pressure	
Other(specify):	
Endocrine/Hormonal Conditions	
Diabetes: Type 1 ☐ Type 2	☐
Thyroid conditions (specify):	
Other (specify):	

Neurological Conditions	✓
Stroke	
TIA/Mini stroke	
Dementia/Alzheimer's	
Epilepsy/seizure conditions	
Other (specify):	
Cancer	
Current ☐ Previous	☐
Location/Type (specify):	
Communicable Diseases	
HIV/AIDS	
Hepatitis: Current ☐ Previous	☐
Hep A ☐ Hep B ☐ Hep C	☐
Other (specify):	

Liver Conditions (specify):
Kidney Conditions (specify):
Skin Conditions (specify):
Eye Conditions (specify):
Muscular Conditions (specify):
Bone/Skeletal Conditions (specify):
Stomach/Intestinal (specify):
Other relevant(specify):

Marital status: Single ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **De facto** ☐ **Widowed** ☐ **Child (under 16)** ☐

Do you have an Advanced Health Directive? Y ☐ **N** ☐ **Please provide a copy for filing*

Do you have an Enduring Power of Attorney? If so who? Y ☐ **N** ☐ **Please provide a copy for filing*

Name :_____ **Relationship:**_____

Address:_____ **Phone No: (____)** _____

Smoking History: Never ☐ **Current** ☐ **-No. per day**_____ **Ex-Smoker** ☐ **-yrs since quitting**_____

Alcohol History: No. Days per week alcohol consumed_____ **No. Drinks per day**_____

Weight (kg): _____ **Height:**_____

***Signature**_____ ***Date:**_____