INVERLOCH HEALTHCARE

Health Information Form - *please give to your doctor or nurse*

Title | Surname | Given Name/s

Date of Birth | Occupation

Do you identify as someone from a culturally or linguistically diverse background? YES NO

If yes, what is your ethnicity? | Languages spoken | What is your country of birth?

Medical History

Do you have any known allergies? YES NO

If yes, to what?

Please describe reaction:

Current Medications

Past or Current Medical Conditions

Heart disorders	YES/NO	Asthma	YES/NO	Blood Pressure	YES/NO
Blood disorders	YES/NO	Kidney Disease	YES/NO	Epilepsy	YES/NO
Arthritis	YES/NO	Migraine	YES/NO	High Cholesterol	YES/NO
Depression	YES/NO	Diabetes	YES/NO	Cancer (inc. Skin)	YES/NO

Other _____

Family History

E.g. Diabetes, blood pressure, heart disease, breast cancer, depression, cause of death if known

Mother _____

Father _____

Siblings _____

Children _____

15 years and cover, please complete

Do you currently smoke cigarettes? YES NO If yes, how many per day?

Have you ever smoked? YES NO If yes, year stopped smoking?

Signature: _____ Date: _____

Name (please print) _____ If not patient, your relationship to patient_____