FAMILY DOCTORS @SMALES | THE TRAVEL CLINIC

Medical Information

Name: ______________________ Date of Birth: ____ / ____ / ____

1. Please tick if you have had or you have a family history of the following:

Condition	Self	Family	Condition	Self	Family
Diabetes			Blood clot		
High Blood Pressure			Stroke		
Heart Disease			High Cholesterol		
Heart Attack			Migraine		
Asthma			Epilepsy		
Lung or respiratory disease or problems			Breast cancer		
Kidney disease			Other cancer		
Liver disease or Hepatitis			Glaucoma		
Bowel Disease			Rheumatic Fever		
Joint disease or Arthritis			Tuberculosis (TB)		
Depression and/or anxiety			Eczema		
Other mental health illnesses			Hay Fever		
HIV					

2. If you have any other health, disability problems or inherited conditions. Please list:

3. Please list any regular medications that you take:

4. Are you allergic to any medications? Yes/No Please list:

5. Have you had any operations? Yes/No. Please list

6. Are you (please circle)

Smoker / Never Smoked / Ex smoker more than 12 months / Ex Smoker less than 12 months?

If you are a smoker would you like help to quit?	**Yes / No**
If you are a smoker less than 12 months would you like help to remain smoke free?	**Yes / No**

FAMILY DOCTORS @SMALES THE TRAVEL CLINIC

7. Women: (*20 years and over & sexually active*)

When was your most recent cervical smear? ____/____/____

Women: (Aged 45 and over)

Have you had a mammogram? **Yes / No**

If yes when was your most recent mammogram: ____/____/____

If you wish to receive our newsletter please fill in your email address.

Your Email Address ______________________________

Note: *Your email address will only be used for our purpose and not distributed.*

Please sign and date that you have read and agree to our Clinic Policy.

Signed: ______________________________ Date: ______________