**PERSONAL HEALTH**

**Surname: …………………………….**

**First name: … (patient stickie)….**

**DOB: …….../….….……/…..………**

Accidents/Injuries………………………………………………………………………………………………………………………………………

Operations………………………………………………………………………………………………………………………………………………...

Chronic Illnesses………………………………………………… Allergies…………………….………………………………………………..

Hereditary Diseases…………………………………….……… Known health problems……………………….………….………….

Current Medications…………………………………………………………………………………………………………….………...................……………

**FAMILY HISTORY** (especially heart, cholesterol, stroke, diabetes, cancer, asthma, eczema)

**Mother’s Health Father’s Health**

Good 🞏 Good 🞏

Problem……………………………….………………… Problem…..…………………………………….…

Deceased (cause)…………………………………... Deceased (cause)……………….…………….

**Brother’s/Sister’s Health Wider Family**

Good 🞏 Good 🞏

Problem………………………………………………….. Problem…..………………………………………..

Deceased (cause)…………………………………….

**SMOKING STATUS :** Please **tick** the space that applies for those aged 15 and over:

Smoking status is an important factor influencing health.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never smoked |  | No longer smoke but in the past smoked daily for more than a year |  | Currently a smoker |

**LIFESTYLE**

**Exercise Recreational Drugs Alcohol**

Less than 3x weekly 🞏 No 🞏 Yes 🞏 No 🞏

More than 3x weekly 🞏 Past Use 🞏 How much each week?

None 🞏 Present Use 🞏 ……………………………

**WOMEN ONLY**

Do you use contraceptives? Yes 🞏 No 🞏 What type?................................................................................................

Number of pregnancies ..................................... Any complications?...............................................................................

Any menstrual problems? .......................................................................................................................................................................................

When was your last cervical smear? ...................................... Any abnormal smears?........................................................................

Have you had a mammogram? ....................... If so, when................................................................................................

**PHYSICAL EXAMINATION - Nursing Staff to fill in**

Height……………..… Weight…………...… BP……………….. Blood Glucose…………...…… Waist Circumference…………..…….

**Vaccinations** Date ofLast tetanus…………………………….. Date of last flu vaccination…….…………….…………… Other:...............................…….............................

**Urinalysis** Albumen…………….… Glucose……………… Blood…..……………...