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Personal Medical Information

Please hand this form to the doctor or primary care nurse during your consultation

Name | Date of Birth

Allergies:

Immunisation:

Childhood	☐ Yes ☐ No ☐ Unsure
Influenza (within the last 12 months)	☐ Yes ☐ No ☐ Unsure
Pneumovax 23	☐ Yes ☐ No ☐ Unsure
Prevenar 13	☐ Yes ☐ No ☐ Unsure
Zostavax	☐ Yes ☐ No ☐ Unsure
Tetanus	☐ Yes ☐ No ☐ Unsure
Fully Covid – 19 Vaccinated	☐ Yes ☐ No ☐ Unsure

Family History: Please include all known significant problems in your family

Father

Mother

Siblings

Grandparents

History

Do you smoke ☐ Yes ☐ No _____ Average quantity per week

Do you drink alcohol ☐ Yes ☐ No _____ Average quantity per week

Most Recent Routine Screenings

Cervical Screening Test (CST)	☐ Yes ☐ No ☐ Unsure	Date if known:
Last Mammogram	☐ Yes ☐ No ☐ Unsure	Date if known:
Bowel Cancer Screening	☐ Yes ☐ No ☐ Unsure	Date if known:
Cholesterol Check	☐ Yes ☐ No ☐ Unsure	Date if known:
BP Check	☐ Yes ☐ No ☐ Unsure	Date if known:
Asthma Check (If applicable)	☐ Yes ☐ No ☐ Unsure	Date if known:
Skin Check	☐ Yes ☐ No ☐ Unsure	Date if known:
Diabetes Check (If applicable)	☐ Yes ☐ No ☐ Unsure	Date if known:

Please turn over

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Personal Medical Information

Please hand this form to the doctor or practice nurse during your consultation

Illnesses and approximate year: Please include all past significant medical problems.

Operations and approximate year: Please include all surgery.

Current Medications (tablets etc.): Include over the counter medications and any vitamins etc.

Please use this space to add any extra information you require

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