springs medical
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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
Recreational Drug use	☐ 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.

Is there anything else that is important to you about your health and wellbeing that you think may assist us in addressing your health needs?

Please use this space to add any extra information you require

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