BROKEN HILL GP SUPER CLINIC
Basic Medical Information

Patient					**ENTERED BY** (Office Use Only)		**PATIENT ID** (Office Use Only)
Title (please tick)	☐ Mr	☐ Mrs	☐ Ms	☐ Miss	☐ Master	☐ Dr	☐ Other
Surname:			Given Names (in full):				
Date of Birth:			Known as:				

Allergies/Sensitivities

Are you allergic to anything and/or to any drugs/medications? ☐ Yes ☐ No

If Yes, please list:

What type of reaction did you have?

Smoking Status (Please tick)

☐ Non- Smoker

☐ Current Smoker - How many per day?

☐ Previous Smoker - Years Ceased?

Alcohol Consumption

☐ Non- Drinker

☐ Social

☐ Regular Consumption per day?

Past History

☐ Diabetes

☐ Hypertension (High Blood Pressure)

☐ Asthma

☐ Depression/Mood Disorder

☐ Other (please specify)

Previous Operations

Please List:

Family History

☐ High Blood Pressure

☐ Heart Disease

☐ Other (please specify)

☐ Diabetes

☐ Breast Cancer

☐ Stroke

☐ Bowel Cancer

Immunisation Status

☐ Tetanus

☐ Boostrix (Tetanus & Whooping Cough Combined)

☐ Hepatitis A

☐ Fluvax

☐ Pneumococcal Vaccination

☐ Hepatitis B

Current Medications

Please List:

Consent to collect Personal Health Information

Name:	Witness (Staff):
Signature:	Date: