TUGGERANONG SQUARE MEDICAL PRACTICE

OPEN 7 DAYS
Phone:02 6175 0400
Fax:02 6293 2970
1/341 Reed St South, Greenway ACT 2900

ABN 25 077 457 53

Medical History Form

This form gives our Medical Practitioners information about your health history which will assist them in your care. This information will be given to your doctor and added to your medical file only and not used for any other purpose. If there are any questions you would rather not answer please, leave them blank.

Your Name:		**DOB:**
Marital Status:	**Number of Children:**	**Blood Group:**
Do you have any of the following conditions (Circle if applicable)	Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression Breast Cancer	
Have any of your immediate family had any of these conditions	Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression Breast Cancer	
Do you have any other medical conditions that Dr should be aware of?		
How often do you exercise?		
Do you drink alcohol?	Yes No	How many per day _____ How many day per week_____
Did you drink in the past?	Yes No	When did you stop?
Do you smoke?	Yes No	How many per day?
Did you smoke in the past?	Yes No	When did you stop?
Have you had previous surgery?	Yes No	When did you have Surgery?

List Allergies	**Reaction**	**List Current Medications**	**Dosage**
List of Current Immunisations			

I acknowledge that the information provided on this registration and information form is correct to the best of my knowledge.

Your Signature _____Date_____