**Medical History.**

 **Date of Birth:** **NHI #:**

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| **MEDICAL HISTORY**  THIS INFORMATION WILL BE ENTERED IN YOUR MEDICAL FILE AND IS CONFIDENTIAL |
| **MEDICAL INSURANCE: Do you have insurance? □ No □ Yes Name of Insurer:**  |
| 1 | **Allergies**: Have you ever had an allergy to medication?□ No□ Yes Please give details: | **Name of medication/s:** |
|  |
| **Type of reaction:** |
| Other allergies? |
| □ No□ Yes Please give details: | **Name of substance (e.g. bee stings):** |
|  |
| **Type of reaction:** |
| 2 | **Please record your smoking history (tick relevant option):***If you would like help to quit, please ask your GP or practice nurse* | □ Never smoked/Vaped□ Quit over 12 months ago. Quit date (approx.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Quit within 12 months ago. Quit date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Currently smoke up to 10/day□ Currently smoke 10 – 19/day□ Currently smoke 20+/day□ Currently Vaping □ Nicotine □ Nicotine Free Vape  |
| 3 | **How many standard drinks of alcohol do you have each week?***If you are worried about your drinking, please talk to your GP or practice nurse* | □ None □ 1 -10 □ 11– 15 □ More than 15  | At least 2 alcohol-free days per week □ Never □ Sometimes □ Often  5 or more on one occasion □ Never □ Sometimes □ Often |
| 4 | **Have you ever had a major medical illness?**□ No□ Yes – please give details: | □ Asthma□ Cancer – please state type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Diabetes□ Epilepsy□ Heart disease□ Kidney disease | □ Liver disease□ Rheumatic fever□ Stroke□ Tuberculosis□ Other – please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 5 | **Have you ever had major surgery?**□ No□ Yes – please give details: | **Operation** | **Date (month/year)** |
|  |  |
| 6 | **Is there any significant illness that runs in your family?**□ No□ Yes – please give details: | **Name of illness (e.g. diabetes, heart disease, stroke):** | **Relationship to you:** | **Age at onset:** |
|  |  |  |
| 7 | **Advance Care Planning: Have you made an Advance Care Plan for future health care and end of life care? Y** □ N □  **If No, please ask us about care plans and conversations around what treatment you would and would not want.**If Yes, would you like to provide us with a copy for your records? **Y** □ N □  |
|  | **Health goals:** Please note any goals you have for your own health here- this can be physical and mental health. | **Physical health goal:** | **Mental health/well-being goals:** |
|  | **Have you ever had a cervical smear test?**□ No □ Not applicable□ Yes – please give details: | **Date (month/year):** | **Result:** |
|  | **Have you ever had a Mammogram?**□ No □ Not applicable□ Yes | **Date (month/year):** | **Result:** | **Where taken:** |
|  |  |  |  |
|  | **Are all childhood immunisations up to date?**  Yes □ No | **If not up to date, please give details:** |