**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:** | | | | |