

Name _____

Allergies

Do you have any allergies or are you sensitive to drugs or dressings? (Please circle)

NO	YES (please specify)
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Medical Conditions (Past and present) (e.g. cancer, heart disease, diabetes, asthma, melanoma etc.)

Operations (Please include the year)

Medications (Current medications including over the counter medications & supplements)

Medication	Strength	How many per day

Family Medical History (e.g. cancer, heart disease, diabetes, asthma, melanoma etc.)

Social History

Alcohol Yes / No If yes days per week : _____ Drinks per day : _____
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Smoker Yes / Never / Ex smoker (year stopped: _____) If you answered yes – how many cigarettes per day do you currently smoke: _____

Marital Status: _____ Children: _____
Occupation: _____
Elite Athlete Yes / No

Vaccinations

Tetanus	Yes / No	Year: _____
Influenza	Yes / No	Year: _____
Pneumococcal	Yes / No	Year: _____