Adult Health Questionnaire

August 2018 V 1.4

Please answer as fully as possible. Please ask for help to fill in the form if needed.

PERSONAL DETAILS

Family Name | Gender ☐ Male ☐ Female ☐ Other

First Name (s) | Date of Birth ☐☐ ☐☐ ☐☐

Preferred Name | Completed by:

PAST MEDICAL HISTORY: √ Have you ever had any of the following?

☐ Asthma ☐ Eczema ☐ Depression ☐ Epilepsy ☐ Migraine

☐ Tuberculosis ☐ Heart Disease ☐ Stomach ulcer ☐ Blood disorders ☐ Diabetes

☐ Rheumatic Fever ☐ Mental Illness ☐ Addictions ☐ High Blood Pressure ☐ Hepatitis

☐ Other ☐ Will discuss with Health Professional

DISABILITIES AND IMPAIRMENTS

✓ Do you have a disability or impairment? ☐ Yes ☐ No

If yes, please state:

MEDICATION

✓ Do you take any regular medication? ☐ Yes ☐ No If yes, GP will discuss with you.

ALLERGIES

✓ Are you allergic to any tablets, medications or injections? ☐ Yes ☐ No

✓ Do you have any other allergies? ☐ Yes ☐ No

If yes, please state:

What was your reaction | When

GENERAL HEALTH QUESTIONS

✓ Have you ever smoked tobacco? ☐ Yes ☐ No Would you like to quit? ☐ Yes ☐ No

✓ If yes, are you? ☐ A current smoker ☐ Ex-smoker – quit date/year _____

✓ Do you vape? ☐ Yes ☐ No

✓ Do you drink alcohol? ☐ Yes ☐ No How many glasses per session? ☐

If yes, ✓ how often? ☐ Once a month or less ☐ 2 – 4 times a month ☐ 2 -3 times a week ☐ 4 or more times a week

✓ How often do you have more than 6 or more glasses per session? ☐ Never

☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

FAMILY HISTORY

✓Has any immediate family member (mother, father, brother, sister) had any of these conditions/diseases?

☐ Asthma ☐ Mental Illness ☐ Osteoporosis

☐ Tuberculosis ☐ Diabetes ☐ Cancer - Type _____

☐ High Blood Pressure ☐ Stroke (see below) ☐ Other _____

☐ High Cholesterol ☐ Heart Attack (see below)

Heart Attack ✓

	Younger than 50 years? ✓ Yes	No	Don't know
Mother	☐	☐	☐
Sister	☐	☐	☐
Father	☐	☐	☐
Brother	☐	☐	☐

Stroke ✓

	Younger than 50 years? ✓ Yes	No	Don't know
Mother	☐	☐	☐
Sister	☐	☐	☐
Father	☐	☐	☐
Brother	☐	☐	☐

PAST VACCINATION HISTORY

✓ Have you been vaccinated against Tetanus? ☐ No ☐ Yes What year?

Do you have an annual flu vaccination? ☐ No ☐ Yes Date last vaccination

Signature: Date: