PATIENT NAME:	DOB:

NEW PATIENT CLINICAL INFORMATION

Do you have any Allergies e.g. Medications/Antibiotics, Iodine/Betadine, Adhesives, Food Allergies etc?

_____
_____
_____

Please list your current medications e.g. Warfarin, Aspirin, Steroids etc:

_____
_____
_____
_____

Please list any current medical conditions e.g. Asthma, Diabetes, heart conditions, Pacemaker, HIV etc:

_____
_____
_____
_____

Have you had any previous operations? ☐No ☐Yes (please list below)

1.	2.	3.
4.	5.	6.

Additional Comments:

_____
_____
_____
_____
_____

Relevant Past or Current Family History:

_____
_____
_____
_____
_____

Do you smoke?

☐ Never ☐ Ex-Smoker ☐ Smoker If so, how many do you smoke a day? _____

Do you consume alcohol?

☐No ☐Yes If 'yes', how many drinks do you consume daily? _____

Do you have private health insurance?

☐No ☐Yes If yes, name of insurance company:_____

What is your current occupation?

Name and Address of Employer (for worker's compensation only):

_____
_____
_____
_____

Phone: Contact person:

Thank you for your time in completing this form

PATIENT NAME:	DOB:

NEW PATIENT CLINICAL INFORMATION

Please list immunisations you have had administered:

Thank you for your time in completing this form