LEESTON MEDICAL CENTRE

## PAGE 3: PRE- REGISTRATION FORM

The aim of this document is to receive accurate notes that will help optimise your healthcare plan. This form will be reviewed by our Nurse to ensure individual current and preventive health needs are added to your health records. Please do have the relevant documents available, when requested.

**FULL NAME: _____ Date of Birth: _____**

**Immunisation History:**

Country of Vaccination: _____
Vaccination Record attached: ☐ YES

Last Tetanus vaccination date: _____/_____/_____
Or unknown: ☐

**Childhood vaccination received:**
6 weeks : ☐
3 months : ☐
5 months : ☐
15 months: ☐
5 years : ☐
11 years : ☐
Unknown : ☐

**Medications and Allergies:**

Are you allergic to any medications?

NO ☐ YES ☐

Please list, and describe the reaction:

_____

_____

**Current regular Medications:**

_____

_____

**Other Allergies?**

Details: _____

**Past Medical History: Have you ever had?**

☐ NO ☐ YES - Diabetes
(Please circle) Controlled by diet/tablets/insulin.
☐ NO ☐ YES - Lung disease
(Please circle) Asthma/ Emphysema/ Chronic Bronchitis.
☐ NO ☐ YES - High blood pressure
☐ NO ☐ YES - Heart Disease
(Please circle) Angina / Heart attack / Heart failure?
☐ NO ☐ YES - Cancer
☐ NO ☐ YES - Depression or mood disorder
☐ NO ☐ YES - Thyroid problems

☐ NO ☐ YES - Operations
If yes, please state the details and date:_____
_____

**Screening History (Female):**

Last Cervical Smear done (year): _____

Previous abnormal smear: YES ☐ NO ☐

Mammograms: (Women only aged 45-70 yrs)

Consented ☐ Declined ☐

Last Screening done (year): _____

Jadelle or IUD placed (If yes, date): _____

**Family History:**

Has your mother, father, brother, sister suffered from heart disease, diabetes, cancer or any other serious health problems?

YES ☐ NO ☐

If yes, please specify: _____

_____

Approximate age occurred: _____

**Alcohol Consumption:**

Do you drink alcohol? YES ☐ NO ☐

If yes,
How many nights on an average week? _____

How many units per session? _____