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: