

Surname	
Name	
Date of Birth	
Patient number	

Patient History and Social Context

Do you have a family member with:	If yes, please specify:		
<ul style="list-style-type: none"> • Asthma • Diabetes • Eczema • Cancer 	<input type="checkbox"/>	<ul style="list-style-type: none"> • High blood pressure • Heart problems • Bleeding disorders 	<input type="checkbox"/>
Previous History	If yes, please specify:		
Medical			
Surgical			
Allergies/Intolerance	If yes, please specify:		
Drugs			
Others			
Risk Factors	If yes, please specify:		
Smoking			
Alcohol			
Other			
Chronic Medication	If yes, please specify name and dosage:		
For ladies only	If yes, please specify:		
Are you (possibly) pregnant?			
Do you use any contraception?			
Do you have children?			
Childhood Vaccinations	Adult Vaccinations (date of last vaccine)		
Diphtheria Tetanus Pertussis		dTpa	
Poliomyelitis		Hepatitis A	
Measles Mumps Rubella		Hepatitis B	
Hepatitis B		Typhoid fever	
Haemophilus Influenza (HiB)		Other	
Meningitis			
Chickenpox			
Other comments	If yes, please specify:		