EASTBRUNSWICK MEDICAL CENTRE

We are committed to providing you with excellent Health Care

East Brunswick Medical Centre Patient Questionnaire.

Date: ___________________________________

Name: __________________________________

Date of birth: ____/___/___

Sex: ☐ Female ☐ Male (Please tick)

You live with: ☐ live alone ☐ partner ☐ children ?how many others (please tick)

Past medical history – please list any significant events, illnesses or operations (eg asthma, appendix removed, childbirth, depression).

Condition: ____ your age then? ______________

Condition: ____your age then? ______________

Condition: ____ your age then? ______________

Condition: ____ your age then? ______________

Condition: ____your age then? _______________

Allergic reactions (to medications, dressings or other allergies eg to nuts) (eg penicillin, rash and swelling)

Name ____________________________________type of reaction? ________________________

Name ____________________________________ type of reaction? _______________________

Immunisations Please bring details of any vaccinations.
Were you fully immunised as a child? YES / NO

Family history

Mother – current age, or deceased? ____

Health conditions- ____

Maternal Grand Mother – current age, or deceased? ___________________________________

Health conditions- ____

Maternal Grand Father – current age, or deceased? ___________________________________

Health conditions- ____

Father – current age, or deceased? ____

Health conditions- ____

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Paternal Grand Mother – current age, or deceased? ______________________________

Health conditions- ____

Paternal Grand Father – current age, or deceased? ______________________________

Health conditions- ____

Sisters & Brothers? How many? Health conditions? Age?

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Medications – Please list all prescribed medications and dosage.
Pleas list any “ over the counter” medications as well>

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