Health Assessment Form

Personal Details:

Name: ____

Address: ____

Phone: (work) _________________ (Home) ________________ (Mob) _________________

Date of Birth: ___________________________Country of birth: _________________________

GP Name: ________________________________Medicare No. _________________________

Marital Status: __________________________ Occupation: ____________________________

Warnings: ____

Allergies/Adverse Reactions:

____

____

Family History:

____

____

Social History:

Alcohol: Y / N Smoking: Y /N

If yes: Smoking Quitting Status: ____

Current Medications:

____

Current Active Problems:

____

Past Medical History:

____

Mental History:

____

Examination:

General: Blood Pressure (Sitting) ______________ Pulse: ______________

Blood Glucose: __________________________ CVS: ___________________

Respiratory:

GIT: _________________

CNS: _________________

Skin: ____

Muscular-Skeletal:

External genitalia: ____

Investigation Results:

HIV: ____

Hep C antibodies: __________________________________

Hep bsag: ____

Chlamydia pcr: _______________________________________

Gonorrhoea pcr: ____________________________________

Dr Name: __________________________________

Dr Stamp: __________________________________