Flagstaff Medical Centre
Screening Information:

Full Name: Mr / Mrs / Ms / Miss

_____

Date of Birth: _____ Ethnicity: _____

Country of Birth:_____

Address: _____Contact Number_____

POA (Power of Attorney for Health)_____Contact Number_____

Next of Kin: _____(Relationship)_____Contact Number_____

Circle appropriate:

Have you ever smoked? Yes / No
Are you a smoker? Yes / No

Do you consume alcohol? Yes / No

Less than 1 pack/day	[ ]	Less than 1 glass/daily	[ ]
1-2 packs/day	[ ]	2-5 glasses/daily	[ ]
More than 2 packs/day	[ ]	More than 6 glasses/daily	[ ]

Have you ever had:		Specify type and Year of Onset/Diagnosis
High blood pressure	[ ]	_____
Operations	[ ]	_____
Asthma	[ ]	_____
Cancer	[ ]	_____
Diabetes	[ ]	_____
Allergies	[ ]	_____

Other ongoing illness: _____

Regular Medications: _____

Has anyone in your family had: eg mother, father, brother, sister etc

High blood pressure	[ ]	Stroke	[ ]
Heart problems (over 60 years)	[ ]	Cancer	[ ]
Heart problems (under 60 years)	[ ]	Diabetes	[ ]

Other ongoing illness_____

Screening:

Date of last smear_____ Date of last mammogram_____

Any abnormal results: Yes / No If yes please specify: _____

How did you hear about us? _____

Would you like to become a registered patient of this practice? Yes / No