

STUDENT HEALTH SERVICES – EDITH COWAN UNIVERSITY

PLEASE PRINT CLEARLY WHEN COMPLETING THIS FORM & **HAND TO DOCTOR WHEN COMPLETED**

PATIENT HEALTH INFORMATION FORM

You can assist your doctor to tailor appropriate and effective ongoing care by providing the information requested in this document.

NAME..... DATE OF BIRTH.....

HEIGHT.....cm WEIGHT.....kg (If unknown we can assist you)

Do you or have you smoked tobacco YES/NO	Consumer of Alcohol YES/NO
Drug use YES/NO type & frequency	

Do you have or have you had a history of? *(Please indicate Yes with a tick)*

Asthma	Diabetes	Hypertension	Epilepsy
Operations <i>(please specify)</i>		Chronic Illness <i>(please specify)</i>	

Do you have any allergies or are you sensitive to drugs or dressings: YES/NO *(if yes please list below)*

Immunisations *(Please indicate Yes with a tick and insert date if known)*

Tetanus booster	Hepatitis A	Hepatitis B
Influenza	Pneumococcal	Polio
Cervical cancer(Gardasil)		

Current medications *(including over the counter medications, vitamins & minerals)* *(Please list)*

Family History – have any members of your family had: *(Please indicate Yes with a tick)*

Asthma	Diabetes	Heart Disease
Mental Illness	Cancer	Chronic Illness

Females: when did you last have? Pap smear Date..... Breast check Date.....

Males: when did you last have? An overall check up Date.....

Children's Immunisations *(If completing this form for a child, are their immunisations up to date?)* YES/NO

For those 65 years and older: when was the last time you were immunised? *(Please indicate Yes with a tick)*

Influenza Date..... Pneumococcal pneumonia Date.....