DAINTREE MEDICAL CENTRE

7 Daintree Way, West Wodonga

Patient Family/Social History

NOTE: *This information is confidential and is for medical treatment only and will not be released to unauthorised persons*

Name: **DOB:**

Address: **Phone:**

Family History

☐ Unknown (i.e. Adopted) ☐ No Significant Family History

Mother Alive? ☐ Yes ☐ No | Age at Death | Cause of Death

Father Alive? ☐ Yes ☐ No | Age at Death | Cause of Death

Significant Family History

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Colon Cancer ☐ Depression ☐ Breast Cancer
☐ Other – Specify:

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Colon Cancer ☐ Depression ☐ Prostate Cancer
☐ Other – Specify:

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Lives with: ☐ Alone ☐ Spouse/Partner ☐ Parent/Relative ☐ Friend

Do you have a Carer? (someone you depend upon to assist with daily activities due to disability, illness or elderliness): ☐ Yes ☐ No

If yes please provide carer Details:

Occupation details

Current Occupation: **Previous Occupation:**

Retired : - ☐ Yes ☐ No

Current Alcohol Intake:

☐ Nil ☐ Days per week: ☐ Number of drinks per day:

Past Alcohol Intake:

☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Year Started: Year Stopped:

Smoking:

☐ Non Smoker ☐ Ex-Smoker ☐ Current Smoker

If Yes, how many cigarettes per day:

Ex –Smoker (smoking history):

How many cigarettes per day:

Year Started: Year Stopped:

FAILURE TO ATTEND POLICY: Missed appointments may prevent other patients from seeing a healthcare professional. A minimum of 3 HOURS notice is required for cancellations. A **"Failure to Attend Fee of $30"** will be incurred for appointments that are missed or for cancellations less than 3 hours prior to appointment time.

The information on this form will be used to form part of your comprehensive medical history.
By signing this form you agree that you have read & agree to Daintree Medical Centre policies available on the noticeboard and on the website. Thank you for your co-operation in completing this form.

PATIENT SIGNATURE: - **Date: - / /**