

# kingsley

M E D I C A L

The following information will help to 'round-out' your medical history and provide more comprehensive preventative and ongoing health care. Please complete the following information and return it to your doctor in person or to the receptionist or email ([km@kingsleymedical.com.au](mailto:km@kingsleymedical.com.au))

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Weight: (kg) \_\_\_\_\_ Height: (cm) \_\_\_\_\_ nurse can assist if unknown  
Country of Birth: \_\_\_\_\_ Are you Aboriginal/Torres Strait Islander? **Yes/No**  
Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Allergies/Intolerances

List all medications, foods, products that you have had allergic or adverse reactions to.  
Please list the type of reaction you have had to each, eg rash, nausea, diarrhoea etc.

\_\_\_\_\_  
\_\_\_\_\_

## Current smoking history

Do you smoke (circle) **Yes No** Year started: \_\_\_\_\_ Cigarettes/cigars per day \_\_\_\_\_

## Past smoking history

Ex-smoker (circle) **Yes No** Year started: \_\_\_\_\_ Year finished: \_\_\_\_\_

Cigarettes/cigars per day during the above period: \_\_\_\_\_

## Current alcohol consumption

Do you drink alcohol (circle) **Yes No**  
Days per week (alcohol consumed) \_\_\_\_\_ Standard drinks per day: \_\_\_\_\_

Past alcohol consumption (circle) Nil Occasional Moderate Heavy

## Family History

Mum alive? **Yes No** Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

Dad alive? **Yes No** Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

Please itemise any Chronic Medical Conditions of family members. This includes: high blood pressure, high cholesterol, cancer, stroke, heart attack, Parkinsons, multiple sclerosis, diabetes, skin cancer.

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Sister: \_\_\_\_\_ Brother: \_\_\_\_\_