CANTERBURY CLINIC

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Clinical Information for Adults (Please give this sheet to the Doctor or Nurse)

As a new patient, completing this form helps us get a detailed overview of your health. This form is confidential and will only be kept in your confidential medical record.

Name: _____ **Date of Birth:** ____/____/____

Your Occupation(s): _____

Any past or current medical/mental health issues:

_____

_____

_____

_____

_____

Any operation/surgery in the past:

_____

_____

_____

Any hospital admissions:

_____

_____

_____

Any medical problems run in your family: (e.g. diabetes, heart problem, stroke, bleeding/clotting disorder...)

_____

_____

_____

Allergies to medications or other substances:

_____

_____

Do you Smoke tobacco? Yes ☐ No ☐ **If no, are you an Ex-smoker?** Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐ **Do you use any recreational/illicit drugs?** Yes ☐ No ☐

List of your current medication: (Including over the counter remedies)

_____

_____

_____

_____

_____

For Women:

Date of last Pap smear: _____ **Any abnormal Pap smears in the past:** Yes ☐ No ☐

Form of contraception (if any): _____