

Flagstaff Medical Centre

Screening Information/Casual Patient:

Full Name: Mr / Mrs / Ms / Miss _____

Date of Birth: _____

Country of Birth: _____ Ethnicity: _____

Address: _____

Contact Number: H) _____ C) _____

Email: _____

Register for Manage My Health: Yes / No

Drivers Licence Number: _____ OR Passport Number: _____

Do you have a Power of Attorney (POA): Yes / No

If yes, has this been activated? Yes / No *Please provide a copy of the POA document to reception.*

Next of Kin/Emergency Contact:

Name: _____ Relationship: _____ Contact Number: _____

Circle appropriate:

Have you ever smoked? Yes / No Do you consume alcohol? Yes / No

Are you a smoker? Yes / No

Amount: _____ Amount consumed: _____

If ex-smoker, year last smoked _____

Have you ever had:

High blood pressure [] Operations: _____

Asthma [] Cancer: _____

Diabetes [] Allergies: _____

Other ongoing illness: _____

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 mammogram _____ Date of last smear _____

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

Name of regular pharmacy: _____