Flagstaff Medical Centre

Screening Information:

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 *Please note you must be aged 16 or over to register for Manage My Health*

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: _____

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