Silverstream HEALTH CENTRE

Patient classification

1 PERSONAL DETAILS

First name _____

Last name _____

Gender* ☐ Male ☐ Female ☐ Gender diverse (please state) _____

DOB / / Height _____ Weight _____

Phone numbers Mobile _____ Home _____

2 EMPLOYER'S DETAILS

Occupation _____

Company name _____

Address _____

Phone number _____

3 SMOKING STATUS

Current smoker ☐ Recently quit ☐ Past smoker ☐ Non-smoker ☐

If you are a *past smoker* or recently quit, when did you quit smoking? _____

If you are a *current smoker*, how many do you smoke per day? _____

If you are a *current smoker*, would you like support to quit smoking? Yes ☐ No ☐

4 ALCOHOL STATUS

Non-drinker ☐ 1-2 standard drinks daily ☐ 4-5 standard drinks daily ☐ Special occasions only ☐

5 CLASSIFICATIONS — Do you suffer from any of the following

Heart issues ☐ Diabetes ☐ Asthma ☐ Allergies* ☐

*Please specify _____

Do you take Warfarin? Yes ☐ No ☐

6 FAMILY HISTORY — Excluding yourself

Please give details and family member

Heart problems	Yes ☐	No ☐	_____
Stroke	Yes ☐	No ☐	_____
Cancer	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Other	Yes ☐	No ☐	_____

Comment on any relevant past medical history not mentioned in this form _____

7 SCREENING HISTORY — Female only

Year and month of last **Mammogram** / Year and month of last **Cervical Smear** /

8 NEXT OF KIN

Name _____

Relationship _____

Address _____

Phone _____