|  |  |
| --- | --- |
| **Given Names:** | **Surname:** |
| **Date of Birth:** | **Occupation:** |
| **Do you believe you work in a high-risk environment?** *eg; Heavy lifting/chemicals* YES □ / NO□ |
| **Health Update:** *If you are* ***FEMALE*** *and aged between 20-65 years, have you had a cervical screening within the last 5 years:* YES □ / NO □ **Date of last Cervical Screening:** \_\_\_/\_\_\_/\_\_\_\_ **Are you Pregnant / Breastfeeding**: YES □ / NO □ |
| **Parents:**Mother: Living □ / Deceased □Cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father: Living □ /  Deceased □ Cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ALLERGIES:** *(Please list below)*  / □NIL KNOWN | **ANY MAJOR OPERATIONS:** |
| **EPILEPSY / FITS:**YES □ or NO □  | **HEART DISEASE:**YES □ or NO □  |
| **CANCER:**YES □ Type:\_\_\_\_\_\_\_\_\_ / NO □  | **KIDNEY DISEASE:**YES □ or NO □  |
| **DEPRESSION / ANXIETY:**Depression □ / Anxiety □ / Not applicable □  | **EMPHYSEMIA / BRONCHITIS / ASTHMA:**YES □ / NO □  |
| **DIABETES:** Type 1 □ / Type 2 □ / Not applicable □ | **HIGH / LOW BLOOD PRESSURE:**High □ / Low □ / Not applicable □  |
| **OTHER:** | **HIGH CHOLESTEROL:**YES □ / NO □  |
| **Current Medications and Dosages: (especially Warfarin or Aspirin, include vitamins and non-script items)** |
|  |
|  |
|  |
|  |
| **Have you had a Care Plan within the last year?** YES □ / NO □ | **Have you had a Mental Health Plan within the last year?** YES □ / NO □ |
| **Do you smoke cigarettes –** YES □ / NO □ If Yes – Year Started \_\_\_\_\_\_\_\_ Number per day\_\_\_\_\_\_\_**Do you consume alcohol –** YES □ / NO □ If Yes – Year Started \_\_\_\_\_\_\_\_ Number per day\_\_\_\_\_\_\_ |

**ACKNOWLEDGEMENT:** I hereby confirm that the above information provided is true and correct.

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_**