



Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Smoker  Yes  No

Urine (Protein and Sugar) Circle one: Negative Positive

Allergies \_\_\_\_\_

Current Medication \_\_\_\_\_

Past Illness/Operations/Pregnancies \_\_\_\_\_

Recent Illnesses (last 12 months) \_\_\_\_\_

Current Drug Medication \_\_\_\_\_

**Immunizations** (Check if given.)

**Child**

- Full Course DPT
- MMR
- Rubella
- Measles

**Adult**

- Tetanus
- Polio
- Travel Vaccinations
- Others (specify) \_\_\_\_\_

**Date**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently on a special diet?  Yes  No If yes, provide details. \_\_\_\_\_

Note any medical restrictions. \_\_\_\_\_

State any religious objections you have to medical treatment. \_\_\_\_\_

**Family Medical History**

- Epilepsy
- Diabetes
- Tuberculosis
- Hypertension
- Heart Disease
- Asthma
- Glaucoma

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Primary Health Care Professional)