Emerald Lakes Medical Clinic

Name: _____ Surname: _____ Date: ___/___/___

Allergies

Do you have any allergies or are you sensitive to drugs or dressings? YES / NO
If yes please specify the name and type of reaction:

Medical Conditions (past and present)

Operations (please include the year)

Medications (Current medications including over the counter medications and supplements)

Medication	Strength	How many per day	What time of day

Family Medical History (past and present – please include who had/has the condition also)
E.g. Cancer, Heart Disease, Diabetes, Mental Health issues, Stroke, Asthma, Eczema

Birth History

Was your child born at full term (38+ weeks)	
Any complications during pregnancy or birth:	

Vaccinations
Has your child had the following vaccinations? (Please circle)

Birth (Hep B)	Yes / No	12 months	Yes / No
2 months	Yes / No	18 months	Yes / No
4 months	Yes / No	4yrs	Yes / No
6 months	Yes / No	other	Yes / No

Social History

How many siblings?	
Does your child attend day care, kindergarten or school (which grade):	
Has your child had any delay with development:	
Any hearing or vision problems:	

Office Use Only

Height: cm Bp: / BSL: (if applicable - at risk, family hx, ?bloods)
Weight: kgs Pulse: Temp: