|  |  |  |  |
| --- | --- | --- | --- |
| Name: | *First:* | *Last:* | *Title:* |
| D.O.B: |  **/ /**  | Gender: M F Other |
| Address: |  |
| Place of Birth: |  | Country of Birth: |  |
| Contact Number/s: | *Home:* | *Mobile:* |
| Email: |  |
| Emergency Contact: | *Name:* | *Contact Number:* | *Relationship:* |

****

|  |
| --- |
| Ethnicity:*(Tick any that you identify with)* |
| * New Zealand European
 |  |
| * Maori
 |  |
| * Samoan
 |  |
| * Cook Island Maori
 |  |
| * Tongan
 |  |
| * Chinese
 |  |
| * Indian
 |  |
| * Other
 | *Please state:* |

|  |
| --- |
| I confirm that:* All the information given is true and current
* I understand I am **not** enrolled or registered with the practice and therefore must pay at the time of the consultation

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| *OFFICE USE ONLY:*ID Sighted: |
| Signed: | Date: |

**Wellington Firefighters Casual Patient Details**

Either bring this form into Capital Care Health Centre at 35 Tennyson St, Te Aro or email to:

admin@capitalcare.org.nz

**Medical History**

Allergies:

Surgeries:

Known medical concerns or family history:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Details |
| Chest pain |  |  |  |
| Rheumatic fever |  |  |  |
| Coronary heart disease |  |  |  |
| High blood pressure |  |  |  |
| Respiratory problems |  |  |  |
| Shortness of breath |  |  |  |
| Immunisations – up to date |  |  |  |
| Smoking – current or previous |  |  |  |
| Alcohol – how often and how much |  |  |  |
| Regular medications |  |  |  |
| Gastrointestinal concerns including bowel habits, weight loss/gain, appetite |  |  |  |
| Skin conditions |  |  |  |
| Sleep habits |  |  |  |
| Musculoskeletal concerns |  |  |  |
|  |  |  |  |
| **Females** |  |  |  |
| Smears – up to date |  |  |  |
| Contraception |  |  |  |