|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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](mailto: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 |  |  |  |