

5. Please list any substances, including medicines and drugs, to which you are allergic:

6. Immunisations:

Are you currently protected against:	Tetanus	YES	NO
	Polio	YES	NO
	Rubella	YES	NO
	Other	-----	

7. Children under 5 - Please list all immunisations and dates.

8. Do you have any family history of the following?

Heart Disease	YES	NO
Thyroid Disease	YES	NO
Diabetes	YES	NO
Asthma / eczema	YES	NO
Other:	-----	

9. FEMALES ONLY –

Have you had a cervical smear?	YES	NO
If YES, what was the date of your most recent?	-----	
How many pregnancies have you had?	-----	
How many have resulted in live births?	-----	
Are you taking oral contraceptives?	YES	NO
Do you have and IUCD fitted?	YES	NO