# Medical certificate

(To be completed by your doctor)

If a Comprehensive Medical Assessment (CMA) has been completed recently please attach a copy

**Patients name:** **Date of birth:** / /

**Current address:**

**Postcode:** **Phone:**

**Current diagnosis:**
(Please attach relevant specialist reports if available)

**Dementia diagnosis:** ☐ Yes ☐ No **Type of dementia:**

**Date of diagnosis:** (Please attach relevant reports if available) / /

**Past Illnesses/Diagnoses:**

## Other medical history

☐ Never smoked ☐ Smoked Age started: ____Age stopped: ____Current cigarettes/day: _____

☐ Alcohol drinks/week: _____

**Other issues impacting on health:**

**Date of last flu vaccination:** / /

**Date of last tetanus:** / /

**Date of last pneumovax:** / /

**Past operations/surgical procedures:**

**Allergies (eg drugs, food, other):** please specify if mild, moderate or severe

**Current medications:**
(Please include all oral, topical, trans-dermal, injected and complementary medications)

## General physical condition

**Weight:** **Height:** **Pulse:**

**Urinalysis:** **BP:**

**Diet:** (Specify any special dietary requirements)

## Skin

**Condition of skin:** ☐ Good ☐ Poor

**Description of skin conditions/ rashes:**

**Wounds/bruises:** ☐ Yes ☐ No

**Current treatment:**

## Sleep

**Rest & sleep patterns:** ☐ Uninterrupted ☐ Interrupted (please give detail):

☐ Sleeping medication (occasional or regular)

Average hours sleep/night:

## Pain

**Painful areas or movements:** (please describe)

**Current pain management strategies:**

## Family history

**Maternal age of death:** **Paternal age of death:**

**Other comments:**

## Doctor's details

**Name of Doctor (please print}:**

**Signature of Doctor:** **Date:** / /

**Address:**

**Postcode:**

**Phone:**

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