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:

J00032I_MAR20

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: