

Welcome to our practice. For information regarding our services and opening hours please ask our reception staff for the practice information booklet.

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate. This information is kept strictly confidential.

Title		<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	<input type="checkbox"/> Dr	<input type="checkbox"/> Other	<input type="text"/>		
Given Names					Surname					
Known As					Date of Birth		Sex		<input type="checkbox"/> M <input type="checkbox"/> F	
Do you identify as being		<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> Neither						
		<input type="checkbox"/> Aboriginal & Torres Strait Islander		Patient #		Expiry Date		<input type="text"/>		
Medicare Number					DVA Number		Expiry Date		<input type="checkbox"/> Gold Card <input type="checkbox"/> White Card	
Pension / Health Care Card Number					Expiry Date		<input type="text"/>		<input type="text"/>	
Private Health Cover		<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Top		Fund Name <input type="text"/>				
Street Address <input type="text"/>										
Suburb & Post Code <input type="text"/>										
Postal Address <input type="text"/>										
Suburb & Post Code <input type="text"/>										
Home Phone <input type="text"/>			Work Phone <input type="text"/>			Mobile <input type="text"/>				
Email <input type="text"/>										
Marital Status		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> De Facto	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	Year of Arrival <input type="text"/>		
Occupation <input type="text"/>				Country of Birth <input type="text"/>			<input type="text"/>			
<b>Next of Kin</b>										
Name <input type="text"/>					Date of Birth <input type="text"/>					
Address <input type="text"/>										
Suburb & Post Code <input type="text"/>										
Home Phone <input type="text"/>			Work Phone <input type="text"/>			Mobile <input type="text"/>				
Relationship to you <input type="text"/>										
<b>Emergency Contact</b> <input type="checkbox"/> Same as Next of Kin										
Name <input type="text"/>					Date of Birth <input type="text"/>					
Address <input type="text"/>										
Suburb & Post Code <input type="text"/>										
Home Phone <input type="text"/>			Work Phone <input type="text"/>			Mobile <input type="text"/>				
Relationship to you <input type="text"/>										
Do you identify as from a culturally diverse and/or non-English speaking background?										
<input type="checkbox"/> China	<input type="checkbox"/> Greece	<input type="checkbox"/> India	<input type="checkbox"/> Iraq	<input type="checkbox"/> Italy	<input type="checkbox"/> Sri Lanka	<input type="checkbox"/> Sudan	<input type="checkbox"/> New Zealand	<input type="checkbox"/> Russia	<input type="checkbox"/> Philippines	
<input type="checkbox"/> Thailand	<input type="checkbox"/> Korea	<input type="checkbox"/> Malaysia	<input type="checkbox"/> Vietnam	<input type="checkbox"/> Other religious, cultural		<input type="text"/>				
Ethnicity <input type="text"/>										
Previous GP Name & Address <input type="text"/>										
<input type="text"/>										

## Patient Medical/Health History

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Reminder System:**

Our practice provides our patients with preventive care and early case detection reminders, eg. immunisations, annual health checks, skin checks and pap smears. We routinely send health reminders.

Please check the box if you do **NOT** wish to have these reminders sent to you

If we need to contact you what is your preferred method of contact:  Phone  Mail  Email

Do you have any allergies or are you sensitive to drugs or dressings  Yes (if yes please list below)  No

**Family History** – Have any members of your family had?

Diabetes \_\_\_\_\_

Asthma \_\_\_\_\_

Heart Disease \_\_\_\_\_

Mental Illness \_\_\_\_\_

Cancer \_\_\_\_\_

**Social History**

Tobacco \_\_\_\_\_ day /week or Ceased Smoking – Date \_\_\_\_\_

Alcohol \_\_\_\_\_ day /week /month (circle the one applicable)

Drug use \_\_\_\_\_  
(Type and Frequency)

Do you have or had a history of?

Operations \_\_\_\_\_

Asthma \_\_\_\_\_

Diabetes \_\_\_\_\_

Hypertension \_\_\_\_\_

Chronic Illness \_\_\_\_\_

Other \_\_\_\_\_

## Patient Medical/Health History

**Immunisation** – Have you had the following immunisation?

Tetanus Booster	<input type="checkbox"/> Yes – Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hepatitis B	<input type="checkbox"/> Yes – Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hepatitis A	<input type="checkbox"/> Yes – Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Influenza	<input type="checkbox"/> Yes – Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Pneumococcal	<input type="checkbox"/> Yes – Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Shingles	<input type="checkbox"/> Yes – Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Whooping Cough	<input type="checkbox"/> Yes – Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

**Children’s Immunisations** – If completing this form for a child are their immunisations up to date?

Yes   
  No   
  Unsure

**Current Medications** (including over the counter medications, vitamins and minerals)

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**Cholesterol:** When was the last time you had a cholesterol check \_\_\_\_\_

What was the level (if known) \_\_\_\_\_

**Blood Pressure:** When was the last time your blood pressure was taken \_\_\_\_\_

**Female** – When did you last have?

Pap smear	Date _____	<input type="checkbox"/> Unsure	<input type="checkbox"/> Never
Breast check	Date _____	<input type="checkbox"/> Unsure	<input type="checkbox"/> Never
Mammogram	Date _____	<input type="checkbox"/> Unsure	<input type="checkbox"/> Never
Skin Check	Date _____	<input type="checkbox"/> Unsure	<input type="checkbox"/> Never

**Males** – When did you last have?

An Overall check up	Date _____	<input type="checkbox"/> Unsure	<input type="checkbox"/> Never
A Prostate check	Date _____	<input type="checkbox"/> Unsure	<input type="checkbox"/> Never
Skin Check	Date _____	<input type="checkbox"/> Unsure	<input type="checkbox"/> Never

**Sun Protection** – How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	<input type="checkbox"/>				
Sunscreen creams	<input type="checkbox"/>				