New Patient Form

Title____________

Surname _________________________________ Given Name ____

Known as (if different to Given Name) ___________________________________Date of Birth ____/____/____

Place of Birth ◻ Australia Other____________________________

Are you of Aboriginal or Torres Strait Islander origin?

◻ No ◻ Aboriginal ◻ Torres Strait Islander ◻ Aboriginal & Torres Strait Islander

Home Address ____Suburb__________________________________

Postal Address ____Suburb__________________________________

Phone (Home) _______________ (Mobile) _______________________ Email ______________________________

Medicare No. _______________________________________Ref no. on card ___________ Exp. ____________

◻ Pension Card ◻Health Care Card ◻Veterans Affairs Card No_______________________ Exp. ____________

Own Occupation______________________________________Employer__________________________________

If your Religion prevents some medical treatments please specify Religion_______________________________

Next of Kin

Name ____Relationship to you ________________________________

Address ____ Contact No. ______________________________

Emergency Contact

Name ____Relationship to you ______________________________

Address ____ Contact No. ______________________________

Our practice uses a reminder system to improve the quality of health care. Reminders are by email, mail or phone for procedures such as vaccinations, cervical screening and other health reviews.

I consent to being contacted with reminders ◻ Yes ◻ No

Preferred means of contact? ◻ home phone ◻ sms ◻ email ◻ letter

Our practice undertakes research, professional development and quality assurance/improvement activities to improve patient care.

I consent to my health records being reviewed as part of the quality improvement activities of this practice

◻ Yes ◻No

How did you hear about us? ◻ Search Engine ◻ Facebook ◻ Word of mouth ◻Promotions

Signature of patient (or guardian) ______________________________________ Date ______________________

Brief medical history

Do you suffer from any of the following
(Please include date of onset if appropriate)

- □ Heart Disease ____________
- □ Diabetes ____________
- □ High Blood Pressure ____________
- □ Thyroid Disorders ____________
- □ Asthma ____________
- □ Bowel Problems ____________
- □ Chronic bronchitis or emphysema ____________
- □ Epilepsy ____________
- □ Arthritis ____________
- □ Kidney Problems ____________
- □ Tumours or Cancer ____________
- □ Stroke ____________
- □ Skin Problems ____________
- □ Depression ____________
- □ Other Mental Illness ____________

Any other relevant history ____

Family History

Mother Alive Yes/No
Cause of Death ____________________
- □ Diabetes ____________________
- □ Breast Cancer ____________________
- □ Colon Cancer ____________________
- □ Stroke ____________________
- □ Heart Disease ____________________

Father Alive Yes/No
Cause of Death ____________________
- □ Diabetes ____________________
- □ Colon Cancer ____________________
- □ Stroke ____________________
- □ Heart Disease ____________________

Personal Social History ____
Elite Athlete yes/no
Allergies ___________________________Reaction ______________________□ Nil Known

Please list any regular medications

Doctor Prescribed	Other

Regular pharmacy used ____

Smoking History
□ Never Smoked □ Current non smoker □ Smoker - Number per day____________________
Do you drink alcohol
□ No □ Yes - Number of days per week _______ Standard drinks per day ____________

When was the last time your blood pressure was taken______________

Females – When did you last have – Pap smear _________Breast check ______________
Skin check ______________

Males – When did you last have – An overall check up __________________
Skin check ________________________
Over 65 – When was the last time you were immunized – Influenza________Pneumococcal ___________

Surname ________________________ Given Name ____________________________________

Signature of patient or guardian: _____________________________________Date ____________________