

# PATIENT INFORMATION FORM

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:

<b>First name:</b>					<b>Surname:</b>								
<b>Street Address:</b>													
<b>Suburb:</b>					<b>Postcode:</b>								
<b>Date of Birth:</b> / /					<b>Sex</b>			<b>M/F</b>					
<b>Occupation</b>													
<b>Home Phone:</b>					<b>Work Phone:</b>								
<b>Mobile Phone:</b>					<b>E-mail:</b>								
<b>Medicare No</b>										<b>Ref</b>		<b>Exp /</b>	
<b>HCC/Pension</b>										<b>Expiry</b>			
<b>DVA</b>		<b>Gold/White</b>								<b>Number</b>			
<b><u>Next of Kin</u></b>										<b>Phone</b>			
Relationship to you													
<b><u>Emergency Contact</u></b>										<b>Phone</b>			
Name										<b>Mobile</b>			

## Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders eg. Immunisations, annual health checks and pap smears

**Do you wish to have any relevant health reminders sent to you?**

Yes – mail     Yes – email     Yes – SMS     No

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

Home Phone     Mobile Phone     Mail     Email

Do you identify as someone from a culturally &/or linguistically diverse background?

Yes – Please elaborate \_\_\_\_\_

To assist with health initiatives are you Aboriginal or Torres Strait Islander?

No     Yes – Aboriginal     Yes- Torres Strait Islander     Yes - both



# HEALTH HISTORY

Do you have or have you had a **history** of?

- Operations (details) \_\_\_\_\_
- Asthma  Diabetes
- Hypertension  Chronic Illness
- Other (details) \_\_\_\_\_

**Do you have any allergies or are you sensitive to drugs or dressings:**

\_\_\_\_\_

**Females** – when did you last have?

- Pap Smear Date \_\_\_\_\_  not sure  never
- Breast Check Date \_\_\_\_\_  not sure  never

**Males** – when did you last have?

- An overall check up Date \_\_\_\_\_  not sure  never

**Children's Immunisations** – if completing this form for a child are their immunisations up to date?  Yes  No

Current Medications (including over the counter medications, vitamins, etc)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History** – have any of your family members had:

- Diabetes  Asthma
- Heart Disease  Mental Illness
- Cancer

**Social History**

Tobacco: \_\_\_\_\_ day / week or ceased smoking –date \_\_\_\_\_

Alcohol: \_\_\_\_\_ day / week / month

Drug Use: \_\_\_\_\_ (type & frequency)