New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Contact Information	
Title:	☐Mr ☐Mrs ☐Ms ☐Miss ☐Mast ☐ Other
Surname:	Middle Name:
First Name:	Preferred Name:
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	Mobile Phone:
Contact Via:	☐SMS ☐Email ☐Mobile ph ☐Home ph ☐Letter
Email:	
Occupation	

Emergency Contact / Next Of Kin Details	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

My Health Record:

Do you consent to your basic health information uploaded in to your "My Health Record"?

E.g.; Immunisations, Allergies, Current medications, Past History.

☐ Yes ☐ No

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

Cultural Identity

Ethnicity: (Where were you born)_____

do you require an interpreter service? ☐ No ☐ Yes

Do you identify as Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

Allergy Information

Do you have any allergies or are you sensitive to drugs or dressings?

☐ No

☐ Yes – provide details

***including what is that you are allergic to and also your reaction mild, moderate, severe, Anaphylaxis, Rash, vomiting, Chest Pain, Diarrhoea.*

Please Turn Over

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Your Health Information

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery – provide details:
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other – provide details:

Do you have a Regular GP?

_____

ALCOHOL CONSUMPTION-

Current alcohol intake:

☐ Non drinker

Days Per Week_____ Standard drinks per day:_____

Past alcohol intake:

☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Year Started _____ Year Stopped _____

CURRENT SMOKING HISTORY-

☐Non Smoker

☐ Ex- Smoker - Year started _____ Year stopped _____

☐ Smoker - Quantity per day _____ Year started _____ Year stopped _____

Family Health History Information

Have any members of your family have:

☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Hypertension (high blood pressure)
☐ Mental Illness
☐ Cancer – type:
☐ Other significant - provide details:

Please Turn Over