NEW PATIENT INFORMATION FORM

Date: _____

How did you find out about this clinic? (Please circle).

Family, Friend, Employer/School, White Pages, Yellow Pages, Front Sign, Medical Specialist, Work Colleague, Infant Welfare Nurse, Internet, Other:_____ (please specify)

PATIENT DETAILS:

PREFERRED TITLE (Please circle): Mr Mrs Ms Miss Dr Other: (Please Specify)

GIVEN NAME: _____ SURNAME: _____

DATE OF BIRTH: _____

MEDICARE NUMBER: _____ REF NO: _____
Reference number is the number before your name

Veteran's Affairs Number (if Applicable): _____

Do you have Private Hospital Insurance? Yes / No - If **'Yes'** is it - Basic, Intermediate or Top Hospital?

ADDRESS: _____

_____ POSTCODE: _____

PHONE: Home: _____ Work: _____

Mobile: _____ **e-mail:** _____

Relationship status (Circle): Single Married De facto Other: _____(specify)

Occupation: _____ COUNTRY OF BIRTH: _____

If Not Australia then Year Arrived: _____

To assist with Health Initiatives:

Are you of Aboriginal orgin ? ☐ YES ☐ NO

Torres Strait Islander origin? ☐ YES ☐ NO

Ethnicity: _____

Preferred Language:_____ Languages Spoken: _____

PERSON YOU WOULD LIKE TO BE CONTACTED IN AN EMERGENCY

Name: _____ Phone: _____

RELATIONSHIP TO PATIENT:_____

DETAILS OF PERSON RESPONSIBLE FOR PAYING ACCOUNTS IF DIFFERENT FROM PATIENT:

PREFERRED TITLE (Please circle): Mr Mrs Ms Miss Dr Other: _____ (Please Specify)

GIVEN NAME: _____ SURNAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____ POSTCODE: _____

PHONE: Home: _____ Work: _____

Mobile: _____

MEDICARE NUMBER:_____ REF. NO._____

RELATIONSHIP TO PATIENT: _____

Please Read and Answer questions carefully. Circle Y/N where appropriate

Remove this page and give it to the doctor during your consultation

Name ……Date ……

Occupation ……..

- Do you have any **allergies**/reactions to **medications?** Y / N .

If yes, which medication/s? ……..……..……

Describe the reaction ……..……..……

- Do you have any **allergies** to **other things**? Y / N .

If yes, which things?……..……...……..……

Describe the reaction ……..……..

……

- Do you have a family history of: Heart Disease ( ) Diabetes ( )

Cancer ( ) Other …….……. (please specify)

If any of the above, which family member/s? ……..…….……

- Are you a smoker? Y / N If yes, how many per day? ……

Ex-smoker? Y / N. Quit Date ……..

- How many glasses of alcohol do you drink per week? ……..

- How much tea, coffee, Coke, Red Bull etc. do you drink per day? ……
- Do you have any ongoing medical conditions? Y / N . If Yes,

please list ...……..……..……....

……..……..……

- Do you have any past medical conditions? Y / N .If Yes,

please list .....….....

.....……

- Do you take any **prescribed medication/s**? Y / N. If Yes,

please list .....

……

- Do you take any '**over the counter' or complementary medications**?

Y / N . If Yes, Please list ……..……

……..……

- Females: Have you had a PAP smear in the last 2 years? Y / N

If Yes, when ? ……