Patient Information Form

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. Could you please assist us by completing the following?

Surname	
First Name	
Date of Birth	
Street Address	
Mailing Address	
Email address	
Home Phone	
Work Phone	
Mobile Phone	
Medicare Number	_ _ _ _ _ _ _ _ _ _ _ Expiry Date: / _ - reference number beside name

If you are on a Pension, Department of Veterans' Affairs Pension, or Health Care Card, please record the details below in the relevant section.	
Pension Number *	Expiry Date: /
DVA Gold / White (circle)*	Expiry Date: /
Health Care Card Number *	Expiry Date: /

* Complete whichever is applicable to you

Emergency Contact		Name		Next of Kin
		Phone Number/s (including mobile)		
		Relationship		

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

☐ Yes ☐ No

Other cultural background? Please specify ……

Patient Consent

Our practice routinely uses text messages to send appointment reminders and recalls for any follow-up scheduled with your doctor. Please indicate if we can use your mobile number for these purposes:

☐ Yes ☐ No

National Prescribing Service (NPS) clinical audits, and various diseases registers to assist with preventative health management (e.g. cervical, breast and bowel screening), involve the doctor recording information on the treatment prescribed or recommended to patients with a particular illness. Please sign the Patient Consent Statement below if you agree to have your ***anonymous*** information used in such studies. Your medical care will not be affected in any way by your decision.

If you would like further information about how your health information is used in these studies please talk to your doctor or ask at reception.

☐ I have read and understand the information above and **I agree** to have my anonymous information included in the studies described.

Patient's signature: ……..Date: ……**P.T.O**

Your Health History

Height: ……. cms Weight: ……. kgs

Do you have a **history** of?

☐ Asthma ☐ Operations .....
☐ Diabetes ☐ Chronic Illness .....
☐ Hypertension ☐ Other .....

Allergies: Do you have allergies or are you sensitive to drugs/dressings: ❑ Yes (list below) ❑ No

Allergy: ..... Reaction: .....
Allergy: ..... Reaction: .....

Immunisations: Have you had the following? Tick if Yes, and provide approximate year

☐ Tetanus Booster ..... ☐ Hepatitis B .....
☐ Influenza ..... ☐ Hepatitis A .....
☐ Pneumococcal ..... ☐ Polio .....

Children's Immunisations – if completing this form for a child, are their immunizations up to date:

☐ Yes ☐ No

Current medications: Do you take any medications (including vitamins & minerals)?

Prescribed: .....
.....
Over the Counter: .....
.....

Family History: Has any member of your family had the following? Tick if Yes, and provide relationship.

☐ Diabetes ..... ☐ Asthma .....
☐ Heart Disease ..... ☐ Mental illness .....
☐ Cancer .....

Social History:

Circle the applicable option

☐ Tobacco – Number per day / week ..... OR ☐ Ceased smoking – date .....
☐ Alcohol – Number of drinks per day / week / month .....
☐ Drug Use (type and frequency) ....

Blood Pressure:

When was the last time your blood pressure was taken? .....

For those 65 years and older – when was the last time you were immunised?

Influenza Date ……. ☐ Not sure ☐ Never
Pneumococcal pneumonia Date ……. ☐ Not sure ☐ Never

Females:

When did you last have?
Cervical screening Date ……. ☐ Not sure ☐ Never
Breast check Date ……. ☐ Not sure ☐ Never

Males:

When did you last have an overall check up? Date ……. ☐ Not sure ☐ Never