

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:

Title	Mr	Mrs	Ms	Miss
Surname				
First Name				
Date of Birth				
Street Address				
Suburb and Post Code				
Home Phone				
Work Phone				
Mobile Phone				
Email				
Medicare Number			Expiry Date	
DVA Gold/White (Please Circle)			Expiry Date	
Pension Number			Expiry Date	
Health Care Card Number			Expiry Date	
Private Health Cover				
Next of Kin (Name and Telephone Number)				
Emergency Contact	(Name and Telephone number of the person we can contact if needed)			

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

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

Yes – Mail Yes – email at this address

Yes – SMS to this phone number No

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

Home Phone Mobile Phone Mail Email

Do you have any health concerns that you would like to receive more information on?

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Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally and/or linguistic diverse background?

Yes – Please elaborate

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

Yes – Aboriginal Yes – Torres Strait Islander Yes – Aboriginal & Torres Strait Islander No

Your Health History – do you have or have you had a history of?

Operations

Asthma

Diabetes

Hypertension

Chronic Illness

Other

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

Yes (If yes please list below) No

Immunisations – Have you had the following Immunisations?

Tetanus booster	Date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Hepatitis B	Date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Hepatitis A	Date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Influenza	Date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Pneumococcal	Date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Polio	Date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one

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 and minerals):

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Family History – have any members of your family had:

Diabetes

Asthma

Heart Disease

Mental Illness

Cancer

Social History

Tobacco: _____ day / week or Ceased Smoking – date _____

Alcohol: _____ day / week / month (circle the one applicable)

Drug Use: _____ (type and frequency)

Height: _____ cms

Weight: _____ kgs.

Blood Pressure: when was the last time your blood pressure was taken?

Sun Protection: How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunscreen Creams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Influenza	Date _____	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never
Pneumococcal pneumonia	Date _____	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never

Females: When did you last have?

Pap Smear	Date _____	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never
Breast Check	Date _____	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never

Males: When did you last have?

An overall check up	Date _____	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never
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