Young Person 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.

Your details

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**	
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)			
Employer Name				
Employer Address				
Employer Telephone No.				

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 – to my home address

☐ Yes – another postal address (please provide) ……

☐ Yes – SMS to this phone number ……

☐ No – I don't want any health reminders

If we need to contact you what is you preffered method of contact:

☐ Home Phone ☐ Mobile Phone ☐ Mail

Do you have any health concerns that you would like to receive more information on? If yes, please elaborate;

_____

_____

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_____
_____
_____

Health History

Your health history – do you have or have you had 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 _____	☐ Don't Know	☐ Haven't had one
Hepatitis B	Date _____	☐ Don't Know	☐ Haven't had one
Hepatitis A	Date _____	☐ Don't Know	☐ Haven't had one
Influenza	Date _____	☐ Don't Know	☐ Haven't had one
Pneumococcal	Date _____	☐ Don't Know	☐ Haven't had one
Polio	Date _____	☐ Don't Know	☐ Haven't had one

Current Medications (including over the counter medications, vitamins and minerals):

_____
_____
_____
_____
_____

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Family History

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.

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

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen Creams	☐	☐	☐	☐	☐

When did you last see a GP? Date _____ ☐ Not sure ☐ Never

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