Springwood Group General Practice

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/s	**Known as**		
Date of Birth			
Street Address			
Suburb and Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Medicare Number		**Expiry Date**	**Reference number (left of name)**
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)	Relationship		
Emergency Contact	(Name and Telephone number of the person we can contact if needed, **not in the same household)** Relationship		
Employer Name			
Employer Address			
Employer telephone no.			
Occupation			
Country of Birth			

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

☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email

****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……

☐ What is your preferred language (if not English)……

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

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Cultural background (this is not compulsorily)……

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Your health history - do you have or have you had a history of? **Date & year if possible**

☐ Operations

_____

☐ Asthma

_____

☐ Diabetes

_____

☐ High Blood Pressure

_____

☐ Other illness

_____

Do you have any allergies? Are you sensitive to drugs or dressings?:

☐ Yes (If yes please list below & your reaction) ☐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

Children's immunisations - if completing this form for a child are their immunisations up to date?

☐ Yes ☐No

Current medications & dosage if known.
(including over the counter medications, vitamins and minerals):

1_____ 7_____

2_____ 8_____

3_____ 9_____

4_____ 10_____

5_____ 11_____

6_____ 12_____

Family History-have any members of you family had the following and if so who:eg.mother, father etc

☐ Diabetes

_____

☐ Asthma

_____

☐ Heart Disease

_____

☐ Mental illness

_____

☐ Cancer

_____

☐ Bowel Cancer

_____

☐ Ovarian Cancer ☐ Breast Cancer

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Social history

☐ Marital Status: Single/ Married/ Divorced/ Widowed/ Defacto (circle the one applicable)

☐ Sexuality – Heterosexual/ Homosexual/ Bisexual

☐ Occupation_____

☐ Tobacco: Y/N_____ day / week Start date_____ or Ceased Smoking - date _____

☐ Alcohol: Y/N _____ day / week / month (days per week/month) How many standard drinks_____

☐ Drug use: Y/N _____ (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	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

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?

Pap smear	Date_____	☐ not sure	☐ never	☐ Result_____
Mammogram	Date_____	☐ not sure	☐ never	☐ Result_____

Males: When did you last have?

An overall check up	Date _____	☐ not sure	☐ never
Prostate Check	Date_____	☐ not sure	☐ never