

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:

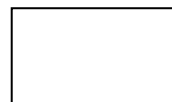
- Home phone
 Mobile phone
 Mail
 Email

****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	<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 _____ 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
