PATIENT INFORMATION SHEET

Title_____ Surname _____ Given Name _____

Known as (if different to Given Name) _____Date of Birth ____/____/____

Place of Birth ☐ Australia Other_____

Are you of Aboriginal or Torres Strait Islander origin? No ☐

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

If your Religion prevents some medical treatments please specify religion_____

Medicare No: _____ **Your ref no. on card** _____ **Exp**: _____

Private Ins. ☐ No ☐ Yes Fund Name: _____ No: _____

☐ Pension Card ☐ Health Care Card ☐ Veterans Affairs. Card No _____**Exp**. _____

Occupation: _____Employer_____

Home Address: _____Suburb_____

Postal Address: _____Suburb_____

Phone: (Home) _____ (Mobile) _____ Email: _____

Next of Kin

Name: _____ Relationship to you: _____

Address _____ Contact No: _____

Emergency Contact

Name: _____ Relationship to you: _____

Address _____ Contact No: _____

Our practice uses a reminder system to improve the quality of health care. Reminders are by email, mail or phone for procedures such as vaccinations, pap smears and other health reviews. **I consent to being contacted with reminders ☐ Yes ☐ No**

Preferred means of contact ? ☐ home phone ☐ sms ☐ email ☐ letter

Our practice undertakes research, professional development and quality assurance/improvement activities to improve patient care.

I consent to my health records being reviewed as part of the quality improvement activities of this practice ☐ Yes ☐ No

How did you hear about us? ☐ Search Engine ☐ Facebook ☐ Word of mouth ☐ Promotions

Signature of patient or guardian: _____Date _____

BRIEF MEDICAL HISTORY

Do you suffer from any of the following:
(Please include date of onset if appropriate)

- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Thyroid Disorders _____
- ☐ Asthma _____
- ☐ Bowel Problems _____
- ☐ Chronic bronchitis or emphysema _____
- ☐ Epilepsy _____
- ☐ Arthritis _____
- ☐ Kidney Problems _____
- ☐ Tumours or Cancer _____
- ☐ Stroke _____
- ☐ Skin Problems _____
- ☐ Depression _____
- ☐ Other Mental Illness _____

Any other relevant history _____

Family History

Mother: Alive Yes/No
Cause of Death _____
- ☐ Diabetes _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Stroke _____
- ☐ Heart Disease _____

Father: Alive Yes/No
Cause of Death _____
- ☐ Diabetes _____
- ☐ Colon Cancer _____
- ☐ Stroke _____
- ☐ Heart Disease _____

Social History _____ Elite Athlete yes/no

Allergies _____Reaction _____ Nil Known ☐

Please list any regular medications

Doctor Prescribed	Other

Regular pharmacy used _____

Smoking History ☐ Never Smoked ☐ Current non smoker ☐ Smoker - Number per day_____

Do you drink alcohol ☐ No ☐ Yes - Number of days per week _____ Standard drinks per day _____

When was the last time your blood pressure was taken_____

Females – When did you last have – Pap smear _____Breast check _____Skin check_____

Males – When did you last have – An overall check up _____Skin check_____

Over 65 – When was the last time you were immunized – Influenza_____Pneumococcal _____

Surname _____ Given Name _____

Signature of patient or guardian: _____Date _____