New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing this form:

Contact Information: *(please print in block letters)*			
Gender:			
Title:			
Surname:			
First Name:			
Date of Birth:			
Street Address:			
Postal Address (if different to above):			
Home Phone:			
Work Phone:			
Mobile Phone:			
Email:			
Emergency Contact:			
Name & Relationship to you:			
Home Phone:			
Work Phone:			
Next of Kin:			
Name & Relationship to you:			
Home Phone:			
Work Phone:			
Healthcare Identifiers:			
Medicare Number		Ref:	Expiry: /
Dept of Veteran Affairs:		☐ Gold	☐ White
Concession Card Number (Pension/Health Care)			Expiry: /

Cultural Identity:

To assist with health initiatives, do you identify as Aboriginal and/or Torres Strait Islander?

☐ *Yes, Aboriginal* ☐ *Yes, Torres Strait Islander* ☐ *Yes, Aboriginal and Torres Strait Islander*

☐ No, Australian ☐ No, *Other*: ....

As Australia is a genuinely multicultural society, and to tailor appropriate health care, encourage understanding and appreciation between people from different nationalities and cultures – do you identify as someone from a culturally and/or linguistically diverse background?

☐ No ☐ *Yes, please elaborate:*

If yes, do you require an interpreter service? ☐ No ☐ Yes

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Your Health Information:

Allergy Information – Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ *Yes, provide details:*

Current Medications – Please list all of your current medications, including complementary and over the counter medicines *(eg homeopathic medicines, vitamins and minerals etc)*

Medical History – Do you have or have you had a history of the following?

☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other – provide details:

Lifestyle Risk Factors:

Are you a smoker?

☐ No ☐ Ceased – date............/ .... ☐ *Yes, how many: .... day / ....week*

Do you drink alcohol?

☐ No ☐ *Yes,* how many: *…………. day / …………. week / …………. Month*

Do you use recreational drugs?

☐ No ☐ Yes, type …………………………. frequency ………………………….

Family Health History Information

Have any members of your family been affected by any of the following medical conditions? *(please state relationship):*

☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Hypertension (high blood pressure)
☐ Cancer – type:
☐ Other significant condition – provide details:

Immunisations

Please list any recent immunisations you have had:

If completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No ☐ Unsure