New Patient Information Form

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.
Please assist us by completing the following:

Surname:	**Title:**	**Maiden Name:**
First Name: (as listed on your Medicare Card)	**Known As:** (what you prefer to be called)	
Date of Birth:	**Marital Status:**	
Street Address:	**Town/Suburb:** (Gillen, Sadadeen, Larapinta etc)	
Postal Address: (if different to street address)	**Local Suburb:** (Gillen, Sadadeen, Larapinta etc)	
Home Phone:	**Work Phone:**	
Mobile:	**Email:** (Please Print Clearly)	
DVA Gold/White Card: (Veterans Affairs)		**Expiry Date:**
Pension Card:		**Expiry Date:**
Health Care Card:		**Expiry Date:**
Medicare Card:		**The final number appears on the Medicare Card just before your name**
Occupation:		
Next of Kin/Partner: (Full Name & Phone)		**Relationship to you:**
Alternate Emergency Contact: (Full Name & Phone)		**Relationship to you:**

Reminder Systems:

Our practice provides patients with online newsletters, preventive care and early case detection reminders. These may include immunisations, annual health checks, blood pressure checks, skin checks and pap smears. Appointment reminders are sent by SMS only.

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

☐ ALL ☐ Phone or Mail ☐ Email

To assist with health initiatives - Are you of Aboriginal or Torres Strait Islander origin?

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ATSI ☐ Neither ☐ Other -please specify_____

Do you have any allergies or are you sensitive to drugs or dressings:

☐ No ☐ Yes (please list) _____

What was the reaction? _____

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

_____

_____

_____

PTO

Proud to be working with the community to improve Central Australian Health.

All information collected will remain confidential.

Your Health History –

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 **Immunisation Objectors?** ☐ Yes ☐No

Have you been diagnosed with:

☐ Asthma (year) _____ ☐ Diabetes Type I (year) _____ ☐ Diabetes Type II (year) _____

☐ Hypertension and/or heart disease (list condition & year diagnosed) _____

☐ Chronic Illness (list condition & year diagnosed) _____

☐ Other (list conditions & year diagnosed) _____

Please list any operations you have had (including date/year performed)

_____

_____

Family History - Have any members of your family had the following? (List whom)

☐ Diabetes _____ ☐ Asthma_____

☐ Heart Disease _____ ☐ Mental illness_____

☐ Cancer _____ ☐ Other _____

Social History

Tobacco

☐ Never Smoked ☐ Ex-Smoker Quit Date _____ ☐ Current Smoker: _____ per day How many years? _____

When was your last quit attempt? _____ What is the longest time you have quit for? _____

Alcohol

☐ Non-Drinker ☐ Alcohol (standard drinks): _____ per day ***or*** _____ per week ***or*** _____ per month

Are you concerned about your alcohol intake? ☐ Yes ☐ No

☐ Drug use: _____ (type and frequency)

Blood Pressure: When was the last time your blood pressure was taken?_____

Do you remember what it was?:_____

Blood Glucose Level (BGL): Have you ever had your level tested?_____

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: <u>When did you last have?</u>

Pap smear	Date_____	☐ not sure	☐ never
Have you ever had an abnormal smear result?		☐ Yes If Yes, Do you know what it was? _____	
Breast Check	Date_____	☐ not sure	☐ never
Mammogram	Date_____	☐ not sure	☐ never

Males: <u>When did you last have</u>?

An overall check up Date _____ ☐ not sure ☐ never

Do you have any other health issues or topics you would like to list?

_____

_____

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