Primary care medical clinic
empathy+care

New Patient Form

We require this information to provide the best quality care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice.

Title: ☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Other: _____

Surname: _____ **Given Names:** _____

Date of Birth: _____ ☐ **Female** ☐ **Male**

Medicare Number: _____ Reference Number: _____ Expiry Date: _____

Pension Card, Health Care Card or Veterans Affairs Card ***(please circle):***
Concession Card Entitlement Number: _____ Expiry Date: _____

Home address: _____ Suburb: _____ Postcode: _____

Postal address _____ Suburb: _____ Postcode: _____

Phone Home: _____ Work: _____ Mobile: _____

Occupation: ☐Retired ☐Unemployed ☐Housewife ☐Studying ☐Other: _____

Marital status: ☐Single ☐Married ☐Defacto ☐Separated ☐Divorced ☐Widowed

Next of Kin/Emergency Contact
Full Name: _____ Phone Contact Number: _____

Relationship to you: ☐Partner ☐Parent ☐Child ☐Friend ☐Other: _____

Culture Backgrounds
Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities do you identify as any of the following?
☐Aboriginal ☐Torres Strait Islander ☐Aboriginal & Torres Strait Islander ☐Other: _____

Practice Reminder System
Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccination, Pap tests and other health reviews.

I consent to being contacted with reminders as a part of the quality improvement activities at this practice.
☐ Yes ☐ No

Transfer of Health Information
You may have consistently consulted with a GP at another practice. The health information held by that GP might assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Signature of patient or guardian: _____ Date: _____

Dear Patient,

We would appreciate your assistance in filling out this form in order to keep your records.

Please be assured that the information you provide will remain confidential. Any queries please speak to your doctor. Upon completion of this form, please hand it to your doctor.

Thank you.

Name:_____ **Date of birth:**_____/_____/_____

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

_____

_____

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

☐ Nil Known ☐Yes Please list:_____

Medical History

Do you have or have you had a history of:

Asthma	☐No	☐Yes
Diabetes	☐No	☐Yes
Hypertension	☐No	☐Yes
Other	☐No	☐Yes (Please specify)_____

Have you had any operations

Details:_____ Date:_____

Details:_____ Date:_____

Details:_____ Date:_____

When was your last Pap Smear: *(women only)* ___/___/___ Normal/abnormal *(please circle)*

Family History

Do you have a family history of any serious illness or disease: ☐No ☐Yes

If yes, of any please specify which relative *(eg. mother, father)*

Diabetes	☐No	☐Yes _____
Asthma	☐No	☐Yes _____
Heart Disease	☐No	☐Yes _____
Cancer	☐No	☐Yes _____
Other	☐No	☐Yes _____

Social History

Do you live with: ☐ Family ☐ Relative ☐ Friends ☐ Other:_____

Do you smoke?

☐Never Smoked ☐ Ex smoker Quit date: __/___/___

Smoker ☐ Number of cigarettes per day:_____

Do you drink alcohol?

Days a week drinks alcohol: Never ☐ Daily ☐ 1-2 Days ☐ 3-4 Days ☐ 5-6 Days ☐ Other:_____

How many standard drinks per occasion?_____