Knoxfield and Colchester Medical Centres

310 Colchester Road, North Bayswater Vic 3153
34 Riddell Road, Wantirna South Vic 3152

New Patient Medical History

Patient Details

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname: _____ **First Name:** _____

Date of Birth: _____/_____/_____

Street Address: _____

Suburb: _____ **Postcode:** _____

Phone: H _____ W _____ M _____

Email: _____

Concession Cards

Medicare Card Number _____ Ref _____ Expiry:_____

Pension/HCC Number _____ Expiry:_____

DVA Card Number _____ Expiry:_____

Next of Kin

Name: _____ Relationship: _____ Phone: _____

Emergency Contact (if different to Next of Kin)

Name: _____ Relationship: _____ Phone: _____

Past Medical Records/History

Would you like to transfer your past medical records/history to KCMC?

☐ No ☐ Yes, from: _____

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?

☐ No ☐ Yes _____

Are you an Aboriginal or Torres Strait Islander?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Please Turn Over

Reminder Systems
Our practice provides our patients with preventive care and early case detection reminders (e.g. immunisations, annual health checks, skin checks and pap smears)

Do you agree to having relevant health reminders sent to you: ☐ Yes ☐ No
If yes, do you agree to having these reminders sent to you via Email or SMS ☐ Yes ☐ No

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

☐ No ☐ Yes _____

Do you or have you had a history of the following? (please elaborate)

☐ Operations _____ ☐ Asthma _____

☐ Diabetes _____ ☐ Hypertension _____

☐ Chronic Illness _____

☐ Other: _____

Immunisations
Have you had the following immunisations? (List date where appropriate)

Tetanus Booster	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis B	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis A	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Influenza	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Pneumococcal	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Polio	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know

Children's Immunisations
If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

Current Medications
Please list all current medications including over the counter medications, vitamins and minerals:

_____ _____

_____ _____

_____ _____

Is there anything else you would like your doctor to know?

_____

_____

Signed: _____ Date: _____/_____/_____