New Patient Information Form

MOUNT SHERIDAN MEDICAL PRACTICE

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.

*** FIRST NAME**
*** SURNAME** *** MRS MS MR**
*** DATE OF BIRTH**
*** MEDICARE NUMBER** **Ref No.** **Expiry Date**
***DVA Gold / White** **Expiry Date** *(Please Circle)*
*** CONCESSION CARD** ***eg: Pension/HCC/Seniors HCC*** **Ref No.** **Expiry Date**
*** RESIDENTIAL ADDRESS**
*** POSTAL ADDRESS**
*** HOME PHONE** **WORK PHONE** **MOBILE**
EMAIL
MARITAL STATUS
OCCUPATION
COUNTRY OF ORIGIN
**** DETAILS OF YOUR NEXT OF KIN or EMERGENCY CONTACT***
*** NAME**
*** RELATIONSHIP TO PATIENT**
*** ADDRESS**
*** PHONE NUMBER**

DO YOU REQUIRE AN INTERPRETER SERVICE ☐ Yes ☐ No

TO ASSIST WITH HEALTH INITIATIVES:

Are you of Aboriginal origin? ☐ Yes ☐ No

Torres Strait Islander origin? ☐ Yes ☐ No

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 wish to have any relevant health reminders sent to you? ☐ Yes ☐ No

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

☐ Yes (If yes please list below) ☐ No

_____

Your Health History - Do you have or had a history of?

☐ Operations _____

☐ Hypertension _____

☐ Asthma _____

☐ Chronic Illness _____

☐ Diabetes _____

☐ Other _____

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 is their immunisations up to date?

☐ Yes ☐ No

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

_____

_____

_____

Family History - Has any members of your family had?

☐ Diabetes _____

☐ Heart Disease _____

☐ Asthma _____

☐ Mental illness _____

☐ Cancer _____

Social History

☐ Tobacco:_____day / week or Ceased Smoking – date_____

☐ Alcohol: _____ day / week / month (circle the one applicable)

☐ Drug use_____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs

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

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: When did you last have?

Pap smear	Date_____	☐ not sure	☐ never

Males: When did you last have?

An overall check up	Date _____	☐ not sure	☐ never

Patients Signature or Parent / Guardian (if child is a minor)