

## New Patient Details Form

Date of initial consultation: ..... / ..... / .....

Title:  Mr  Mrs  Ms  Miss  Master  Dr

Last Name: ..... Given Names: .....

Date of Birth: ..... Gender: .....

**The following information will assist us in the planning and provision of the best possible care:**

Are you of Aboriginal or Torres Strait Islander origin?

No  Yes, Aboriginal  Yes, Torres Strait Islander  Both, Aboriginal and Torres Strait Islander

What is your cultural background? .....

Country of Birth: ..... Is English your first language?  Yes  No

If English is not your first language, do you require an interpreter?  Yes  No

Street Address: .....

Suburb: ..... Postcode: .....

Home Phone No: ..... Work Phone No: .....

Mobile No: ..... Email: .....

How would you like us to contact you?  Home Phone  Work Phone  Mobile  Email  Post

Can we SMS or leave a message on your message-bank regarding an appointment?  Yes  No

Can we leave a message with a family member who answers the phone regarding an appointment?  Yes  No

If yes - please state their name and relationship to you: .....

Can we put your name on a formal reminder system for preventive care?  Yes  No

**PLEASE SIGN HERE IF YOU CONSENT TO THE ABOVE:** .....

Medicare Card No:  Ref:  Expiry Date: .....

Health Care Card or  Pension Card No: ..... Expiry Date: .....

DVA Card No: ..... Expiry Date: .....  Gold  White

Next-of-Kin: ..... Relationship:..... Ph No: .....

Emergency Contact: ..... Relationship:..... Ph No: .....

Occupation: .....

**How did you hear about this practice?** (OK to tick more than one box)

Yellow Pages  Doctor  Newspaper / Weekly  Facebook

Yellow Pages Online  Employer  Google Search  Friends or Family

Passing By  Signage  Other: .....

**Privacy Statement:**

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the *Privacy Act (1988)* and *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE

Signature:..... Date: .....

Name: ..... Date of Birth: .....

Smoking:  Non-smoker  Smoker - how many/day: .....  Ex-smoker - year stopped: .....   
Alcohol:  Non-drinker  Drinker - how many days/week: ..... How many std drinks/day: .....   
Past Drinker:  No  Yes:  Occasional  Moderate  Heavy   
Year started (if known): ..... Year stopped (if known): .....

What is your weight: ..... What is your height: .....

Please list any medications that you are currently taking (including vitamins and herbal medicines):   
Name of medication: ..... Strength: ..... Daily Dose: .....   
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Have you had any immunisations recently?  Flu Vaccine  Pneumococcal Vaccine  Other - please state: .....   
.....  
If child - are all childhood immunisations up-to-date?  Yes  No: .....

Do you have any significant past medical history?  No  Yes: .....   
.....

Do you have any known allergies?  No  Yes: .....   
.....  
Have you ever had an allergic reaction?  No  Yes: .....

Do you have any significant family history?  Don't know  No  Yes - please complete details below:   
 Diabetes  Type 1  Type 2 Family Member: .....   
 Cancer Type of Cancer: ..... Family member: .....   
 Heart Disease Family member: .....   
 Hypertension Family member: .....   
 Stroke Family member: .....   
 Depression Family member: .....   
 Other: .....   
Mother - alive?  Yes  No Age at death: ..... Cause of death: .....   
Father - alive?  Yes  No Age at death: ..... Cause of death: .....

What recreational activities do you participate in? .....   
..... Elite athlete?.....  Yes  No

Marital Status: .....   
Accommodation:  Own home  Nursing home  Other: .....   
Live with:  Alone  Spouse  Relative  Friend

OFFICE USE ONLY: Entered  Scanned