NEW PATIENT INFORMATION

Birth Sex: Male / Female **Title:** **Mr** **Mrs** **Miss** **Master**

Gender Identity (Please Circle): Male, Female, Non-Binary, Gender Diverse, Transgender or Different Identity

Pronouns (Please Circle): She/Her/Hers, He/Him/His, Them/They/Theirs

Given Name: ____________________________________ **Surname:** ____

Preferred Name: ____________________________________ **Date of Birth:** ____

Address: ____

Home Phone: ____ **Mobile:** ____

What Contact Number can Practice Staff call and leave a message on? ____

Are you happy to receive SMS Reminders for Appointments? Yes / No

Email Address: ____

Identification Details:

Medicare No: __________________________ Expiry: ___ / ___

DVA No: _____________________________ Expiry: ___ / ___

Pension/Concess: _______________________ Expiry: ___ / ___

Private Health Fund Details:

Do you have a Private Health Fund: Yes/No

Health Fund: ________________**Number**: ____________________

Cultural Diversity:

Were you born in Australia: **Yes / No** If no, in which country were you born: ____

Do you identify yourself as any of the following: (Tick all that apply) ☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander

Emergency Contact and Next of Kin Details: - Name of the Person You Would Like Practice Staff To Contact In An Emergency:

Next of Kin:__________________________ _ Home Phone: _____________ Mobile No: _________________ Relationship: ____________

Address: ____

Name: ________________________________ Home Phone: _____________ Mobile No: __________________Relationship: ______________

Address: ____

Your Occupation:____

Data Sharing Information & Patient Consent

Due to Confidentiality and Privacy legislation, we are unable to give out information in regards to your personal medical records and investigation results without your consent.

Do you give permission for someone else to have access to your medical records?
Yes / No
Name: ________________________________

Do you have an enduring Power of Attorney?
Yes / No
Name: ________________________________

Do you give permission for someone else to access your investigation reports?
Yes / No
Name: ________________________________

Do you have and advance health directive?
Yes / No
Name: ________________________________

I agree / do not agree to have my medical record reviewed by an AGPAL Surveyor if it is one of the records randomly chosen. I understand this is part of our Practice participating in the accreditation process for General Practice.
Agree ☐ **Do Not Agree** ☐

Doctors at this practice use Pen CS Software to help provide you with the best medical care.

This practice, like others around Australia, securely shares patient health information (that is not identifiable) with Primary Health Networks, to improve health services in this area.

If you would like to opt out please tick this box: ☐

Signature:____________________ **Date:_________**

Patient Name:_____________________________ **Date of Birth:**

Patient Name: ………………………………………… **DOB:**…………………………………

Past History

Have you ever had:

Rheumatic Fever	☐	Diabetes	☐
TB	☐	Epilepsy	☐
Asthma	☐	Blood Pressure	☐
Stroke	☐	Heart Attack	☐
Thyroid Problems	☐	Clots in leg/lungs	☐

Have you ever had operations on:

Tonsils	☐	Appendix	☐
Gall Bladder	☐	Veins	☐
Hernia	☐	Joints/Bones	☐

Any treatment for mental health issues:

Depression ☐ Anxiety ☐ Other ☐

Family and Social History

Mother Alive Yes/No Age at Death:_____ Cause of Death _________________________

Father Alive Yes/No Age at Death:_____ Cause of Death__________________________

Other Significant Family History:

Mother: Diabetes ☐ Colon Cancer ☐ Hypertension ☐
Depression ☐ Heart Disease ☐ Breast Cancer ☐ Stroke ☐

Father: Diabetes ☐ Colon Cancer ☐ Hypertension ☐
Depression ☐ Heart Disease ☐ Breast Cancer ☐ Stroke ☐

Smoking: Non ☐ Ex ☐ Smoker ☐
Year Started ______ Year Finished ______ Number per day _____

Alcohol Intake: Days per week _____ Drinks per day ______

Any exposure to: Dust Asbestos Radiation Animals

Marital Status: ________________

Breastfeeding: Yes/No **Elite Athlete**: Yes/No

Do you have any allergies or are you sensitive to any drugs or dressings: Yes/No
(If yes, pls list) ____
____
____
____

If completing this form for a child, are Immunisations up to date: Yes/No

Patient Name: …………………………………………… DOB:……………………………………….

New Patient – Current Medications List

Please provide your current medication list

Drug Name	Strength	Dose	Frequency (e.g. twice a day)	Reason for Medication

Please provide any Alternative Medications you are taking: e.g. Vitamins, Supplements, Oils

Product Name	Strength	Dose	Frequency (e.g. twice a day)	Reason for taking