New Patient Information Form

Please Complete This Form to the best of your knowledge. Please complete in clear writing

Title	**Dr**	**Mrs**	**Ms**	**Miss**	**Mr**	**Master**	**SURNAME:**	
First Name						**Middle Name**		
Date Of Birth		**Day**		**Month**			**Year**	
Home Address:								
Suburb							**Postcode**	
Home Phone			**Work**				**Mobile**	
Email							**Occupation**	
Are you of Aboriginal or Torres Strait Islander							**Yes**	**No**
(Ethnicity) Country of Birth:							**Language spoken**	
Medicare No/						**Ref. No/**		**Expiry Date:**
DVA Card				**Expiry**			**Colour**	
Pension Card		**Health care Card**				**No/**		**Expiry Date:**
Private Health Insurance Name:								
Next of Kin: Full Name							**Tel:**	
Relationship to you?								
Emergency Contact Person:							**Tel:**	
Relation to you?								
Name and contact number of a person who can be contacted URGENTLY if needed								

How did you hear about us? (Please circle)
Family/Friend , Walk in,Chemist, Facebook ,Flyers, Health Engine, Web search ,Other

Reminder Systems

Our practice provides our patients with preventative care and early case detection eg. Immunisations, annual health check, skin checks and pap smears etc.

Do you wish to have any relevant health reminders sent to you? (SMS Reminders) YES / NO

If we need to contact you, what is your preferred method of contact (please circle) Phone / Email

I provide consent for Argyle Street Family Practice and their affiliates to access and use my personal information so that they can provide me with the best possible healthcare. Only staff who need to see my personal information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do this.

KEEPING YOUR MY HEALTH RECORDS IN A SAFE PLACE :

Would you like us to register you for the MY HEALTH RECORDS YES / NO

Signature of Patient or Guardian: _____ **Date:** _____

It is a legal requirement that we sight Photo I/D ? **Staff Sighted:** _____

Please turn over

Medical History

Please complete the following about your health to help your Doctor

ABOUT YOUR HEALTH - Do you have or have had any history of?

Allergies: _____ **Symptoms:**_____

Operation: **No** **YES- Details:**_____

_____

Asthma: **No** **YES- Details:**_____

High Blood Pressure: **No** **YES- Details:**_____

Any Chronic Illness: **No** **YES- Details:**_____

Do you take any Medications? **No** **YES- Details:**_____

_____

_____

_____

IMUNISATION HISTORY

If this is a child, are immunisation up to date? **YES / NO / NOT SURE**

For Adults immunisations, Have you had any of the following ?

Tetanus Boosters Date:_____ Don't Know Have not had one

Hepatitis A Date:_____ Don't Know Have not had one

Hepatitis B Date:_____ Don't Know Have not had one

Influenza Date:_____ Don't Know Have not had one

Pnemococcal Date:_____ Don't Know Have not had one

Polio Date:_____ Don't Know Have not had one

SOCIAL HISTORY

Do you consume ALCOHOL _____ How many a week? _____

DO YOU SMOKE? YES / NO How many a day? _____

When did you Quit Smoking? _____

What is your Height? _____

What is your weight? _____

FEMALES : When did you have your last PAP SMEAR?_____

MALES: When did you have an overall check up? _____