

patient registration form

We would like to get to know you and help you to live a healthy life. To do this, we need to learn more about your health and the best ways to communicate. The more that you can tell us, the more that we can help. Your information will be treated in strict confidence.

Contact details

Title: _____ Given names: _____ Surname: _____
 Known as: _____ DOB: _____ Gender: M F Transgender
 Address: _____
 Email address: _____
 Contact numbers: Home _____ Work _____ Mobile _____

Other contact details

Next of kin: _____ Relationship to patient: _____
 Contact numbers: Home _____ Work _____ Mobile _____
 Emergency contact: _____ Relationship to patient: _____
 Contact numbers: Home _____ Work _____ Mobile _____

Person in charge of accounts: _____ Relationship to patient: _____
 Address: _____
 Contact numbers: Home _____ Work _____ Mobile _____

Medicare card number: _____ Ref _____ Eligible for concession: Yes No

Personal details (optional)

Marital status: Single Married De facto Separated Divorced Widowed
 Religion: _____ Occupation: _____

Cultural details

Are you Aboriginal or Torres Strait Islander? No Yes Aboriginal Yes Torres Strait Islander Yes Both
 Cultural background: _____ Country of birth: _____
 Language spoken at home: _____ Interpreter required: Yes No

How did you find out about us? Word of Mouth Signage Flyer Event Online
 Google Facebook Twitter Other

Consent

We take an active approach to your health and use different ways to communicate with you for various reasons

Do you give us permission to:

- record your health information for medical and health related services? Yes No
- disclose your health information to other health care providers involved in your treatment? Yes No
- record and use your personal information for billing and administrative purposes? Yes No
- call you to confirm upcoming appointments? Yes No
- send you SMS reminders for upcoming appointments? Yes No
- contact you regarding matters involving your health as part of our follow-up system? Yes No
- send you emails or letters about upcoming health related opportunities at our practice? Yes No

If answered 'No' to any of these questions, please provide more information below or speak to our friendly team:

I (Patient / Guardian Name) _____ agree that this information is accurate and true to the best of my understanding and that there is no other information that would influence the medical treatment or advice to be provided.

Signature _____ Date _____ Patient Guardian

patient history form

Medical history

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

No Yes (please list)

Are you currently using any prescribed or over the counter medications or vitamins and minerals?

No Yes (please list)

Do you have or have you ever had a history of:

Heart problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Migraines	No <input type="checkbox"/> Yes <input type="checkbox"/>
High blood pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>	Asthma, respiratory problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Kidney, bladder problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Skin rashes, dermatitis, eczema, psoriasis	No <input type="checkbox"/> Yes <input type="checkbox"/>
Emotional disorder, anxiety, depression	No <input type="checkbox"/> Yes <input type="checkbox"/>	High cholesterols	No <input type="checkbox"/> Yes <input type="checkbox"/>
Fits, strokes, epilepsy	No <input type="checkbox"/> Yes <input type="checkbox"/>	Liver disease, jaundice, hepatitis	No <input type="checkbox"/> Yes <input type="checkbox"/>
Varicose veins, clots, blocked arteries	No <input type="checkbox"/> Yes <input type="checkbox"/>	Sinus problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Stomach ulcers	No <input type="checkbox"/> Yes <input type="checkbox"/>	Ear or hearing problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Eye or vision problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Serious trauma, major operations	No <input type="checkbox"/> Yes <input type="checkbox"/>
Back, neck, joint problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Sexual dysfunction	No <input type="checkbox"/> Yes <input type="checkbox"/>
Bowel, rectal problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Abnormal pap smear	No <input type="checkbox"/> Yes <input type="checkbox"/>
Prostrate problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Sexually transmitted disease	No <input type="checkbox"/> Yes <input type="checkbox"/>
Thyroid problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	HIV	No <input type="checkbox"/> Yes <input type="checkbox"/>
Sickle cell anaemia, thalassaemia	No <input type="checkbox"/> Yes <input type="checkbox"/>	Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>
Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>	Type	Diagnosis date

Preventative health

When was your last check for the following:

Cholesterol	Date	Not sure <input type="checkbox"/>	Never <input type="checkbox"/>
Blood pressure	Date	Not sure <input type="checkbox"/>	Never <input type="checkbox"/>
Fasting sugar	Date	Not sure <input type="checkbox"/>	Never <input type="checkbox"/>
HIV	Date	Not sure <input type="checkbox"/>	Never <input type="checkbox"/>

Male

Prostate Date Not sure Never

Female

Pap smear Date Not sure Never
 Breast check Date Not sure Never
 Mammogram Date Not sure Never

Immunisation history *If this record is for a child, please also provide immunisation record book at your first appointment.*

Tetanus	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>	Measles	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>
Chicken pox	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>	Polio	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>
Hepatitis A	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>	Hepatitis B	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>
Rubella	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>	Meningococcal	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>
Influenza	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>	Pneumococcal	No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/>

Family history

Have any of your direct relatives ever had:

High cholesterol	No <input type="checkbox"/> Yes <input type="checkbox"/>	Heart disease	No <input type="checkbox"/> Yes <input type="checkbox"/>
Stroke (brain)	No <input type="checkbox"/> Yes <input type="checkbox"/>	Sickle cell anaemia, thalassaemia	No <input type="checkbox"/> Yes <input type="checkbox"/>
Depression, schizophrenia	No <input type="checkbox"/> Yes <input type="checkbox"/>	Asthma, respiratory problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Emphysema	No <input type="checkbox"/> Yes <input type="checkbox"/>	Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>
Thyroid problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Bowel problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Kidney disease	No <input type="checkbox"/> Yes <input type="checkbox"/>	Skin rashes, dermatitis, eczema, psoriasis	No <input type="checkbox"/> Yes <input type="checkbox"/>
Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/>	Other (please specify)	

Social history

Do you exercise? No Yes how many times per week? Duration of exercise?

Do you smoke? No Yes how often? Smoking for how many years?

Do you drink alcohol? No Yes how many days per week? Number per occasion?

Do you use recreational drugs? No Yes how often? What type?

OFFICE USE ONLY

Team member: _____ Date: _____

Identification verified: known to team member licence passport other _____

Medicare called to check item number eligibility Date: _____ Time: _____ Name of Medicare officer: _____