ONE POINT

MEDICAL

Patient Details/Consent

New Patient/Temporary (Visitor)

Title: (please circle) Mr Mrs Ms Miss Mast Dr Prof Rev

Surname: _____First Name: _____

Date of Birth: _____ Sex: M / F /Other

Are you from Aboriginal descent? Yes / No or Torres Strait Islander descent? Yes / No

Other Ethnicity:_____

Marital Status: □ Single □ Married □ Defacto □ Separated □ Divorced □ Widowed

Address: _____

Suburb: _____State:_____ Postcode: _____Country of Birth: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____ Occupation: _____

Medicare No: _____ Patient No: 1 2 3 4 5 6 7 8 Expiry Date: _____/_____

Healthcare/Pension No: (please circle) _____ Expiry Date: _____/_____/_____

Veteran Affairs No: _____ Type: (please circle) Gold White

Emergency Contact (If same address, please write "As Above")

Full Name_____ Address:_____

State: _____ Postcode:_____ _Phone: _____ Mobile: _____

Relationship:_____

Next of Kin: (If the same person, please write "As Above") Relationship: _____

Full Name: _____ Address:_____

State: _____ Postcode:_____ Phone: _____ Mobile: _____

Before you Register Do you consent to:

1. Our practice provides our patients with preventative care and early case detection reminders eg. Immunisation, annual health check, skin checks, pap smears etc. Do you **CONSENT** to being contacted with reminders ?
   YES/NO (please circle)
2. To being contacted as part of our recall system for the follow up of Investigation results?
   YES/NO (please circle) *If no please note if you circle NO you are responsible for booking follow up appointments for your results.
3. Do you **CONSENT** to be contacted/ reminded of appointments via SMS?
   YES/NO (please circle)
4. Our policy on health information collection and use and general research consent (Please ask reception for copies of this consent forms if you require more info)
   YES/NO (please circle)
5. Our no show/ late cancellation Policy (Please ask reception for copy of this consent if you require more info)
   YES/NO (please circle)

Signature: _____ Name: _____ Date: _____

NEW PATIENT MEDICAL INFORMATION SHEET

SURNAME		M / F	Mr / Mrs / Miss / Ms / Mast / Dr / Prof
FIRST NAMES			DATE OF BIRTH

Have you any allergies? (including drugs and dressings)

What illness or operations have you had in the past?

FAMILY HISTORY (Have any of your parents, brothers or sisters had the following)

☐ Melanoma	☐ Diabetes	☐ Heart Attack	☐ Stroke	☐ Bowel Cancer
☐ Hypertension	☐ Depression	☐ Migraine	☐ Asthma	☐ Breast Cancer
☐ Prostate Cancer	☐ Other Information:			

Women Only	Births	Dates	Any Complications

Have you ever had a Pap Smear test? ☐ No ☐ Yes Date of last smear? _____ / _____ / _____

Are you on a contraceptive pill? ☐No ☐ Yes Name of Pill? _____

Have you had a Mammogram? ☐ No ☐ Yes Date of last Mammogram? _____/ _____ / _____

CURRENT MEDICAL PROBLEM (What is the reason for today's visit?)

CURRENT MEDICAL STATUS (What long term problem do you have ……e.g. Heart disease, diabetes, cancer etc)

MEDICATIONS (Please state what tablets or medicines you take)

Name	Dose	Reason

SOCIAL

Smoking	☐ Non Smoker	☐ Ex Smoker	☐ Smoker	Amount _____
Alcohol	☐ Non Drinker	☐ Social Drinker	☐ Moderate Drinker	☐ Heavy Drinker
Exercise	☐ Nil	☐ Regular Exercise	☐ Moderate Exercise	☐ Elite Athlete

IMMUNISATIONS

Are Childhood Immunisations up to date? ☐ No ☐ Yes

Do you have a yearly flu injection? ☐ No ☐ Yes

Date of your last Tetanus Injection? _____ / _____ / _____

Date of your last Pneumonia Injection? (over 65 yrs) _____ / _____

Signature: _____ Name: _____ Date: _____