

New Patient Form



TITLE: <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Mr <input type="checkbox"/> Mast <input type="checkbox"/> Dr <input type="checkbox"/> Other:		OFFICE USE (Practitioner seen):	
SURNAME:		GIVEN NAMES:	
PREFERRED NAME:		DATE OF BIRTH: / /	
MEDICARE NUMBER:		REFERENCE:	EXPIRY DATE:
CONCESSION CARD ENTITLEMENT NUMBER: <input type="checkbox"/> PENSIONER <input type="checkbox"/> HEALTH CARE CARD		EXPIRY DATE:	
DVA CARD: <input type="checkbox"/> GOLD <input type="checkbox"/> WHITE	CARD NUMBER:		EXPIRY DATE:
RESIDENTIAL ADDRESS:		SUBURB:	
POSTAL ADDRESS (If different):		SUBURB:	
HOME PHONE:	MOBILE:	WORK PHONE:	
EMAIL ADDRESS:			
IF THE NEW PATIENT IS A CHILD UNDER 16 PLEASE PROVIDE:			
PARENTS NAME:		PARENTS DATE OF BIRTH:	
PARENT'S MEDICARE NUMBER:			
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> DEFACTO <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> N/A (Children)			
OCCUPATION:		EMPLOYER:	
COUNTRY OF BIRTH:		IF NOT AUSTRALIA, WHAT YEAR DID YOU ARRIVE:	
LANGUAGE SPOKEN OTHER THAN ENGLISH:			
DO YOU IDENTIFY AS BEING ANY OF THE FOLLOWING: <input type="checkbox"/> ABORIGINAL <input type="checkbox"/> TORRES STRAIT ISLANDER <input type="checkbox"/> ABORIGINAL AND TORRES STRAIT ISLANDER <input type="checkbox"/> LGBTQ+			
NEXT OF KIN		EMERGENCY CONTACT	
NAME:		NAME:	
RELATIONSHIP TO YOU:		RELATIONSHIP TO YOU:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
<p>PATIENT PRIVACY INFORMATION: <i>To provide a high standard of care and as an accredited practice we need to record basic personal and health information. This information is treated with the strictest of confidence and may only be divulged to a third party with your consent, unless required by law or in an emergency situation. The staff members of Family Doctors Plus are subject to strict confidentiality obligations. De-identified health information may be used by third parties for quality improvement or research projects. You may opt out of this at any time by informing reception or your doctor. Misleading or inaccurate information may affect our ability to provide the best health outcome for you. Family Doctors Plus uses SMS contact for appointment reminders & to recall patients for outstanding test results. We send letters if you cannot be contacted or do not consent to SMS messages. You may opt out of electronic communications at any time. Please refer to our Privacy Policy found on our website or ask reception for more details.</i></p> <p><i>You may opt out of email or SMS communications at any time by notifying us.</i></p> <p>Do you consent to SMS correspondence from Family Doctors Plus? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>I have read the Privacy statement & Consent. Signature: _____</p>			

BRIEF MEDICAL HISTORY

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Diabetes- Type 1 / Type 2 | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Abnormal Cervical Screening |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Tumours/ Cancers |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> High Cholesterol |

Any other medical conditions/past surgeries:

Allergies/ Adverse Reactions:

Current Medications:

FAMILY HISTORY (INCL. PARENTS, SIBLINGS, GRANDPARENTS):

- ☐ Heart Disease
☐ Diabetes- Type 1 / Type 2
☐ High Blood Pressure
☐ Stroke
☐ Cancer
☐ High Cholesterol

SMOKING: ☐ Never Smoked ☐ Ex- Smoker- Year Quit: _____ ☐ Smoker- Number/ Day: _____

ALCOHOL: ☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+times per week

How many standard drinks would you consume each time you drink: _____

PREVENTATIVE HEALTH:

Have you ever had a Skin Check?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Have you ever had a Colonoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Are your immunisations up to date?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not Sure

WOMEN ONLY:

Have you ever had a Cervical screening: ☐ Yes ☐ No
If yes, date of last Cervical Screening: _____
Was it: ☐ Normal ☐ Abnormal

Have you ever had a Breast Screen: ☐ Yes ☐ No
If yes, date of last Breast Screen: _____
Was it: ☐ Normal ☐ Abnormal

MEN ONLY:

Have you ever had a Prostate Check: ☐ Yes ☐ No

If yes, date of last Prostate Check: _____

Was it: ☐ Normal ☐ Abnormal

IF YOU ARE OVER 65 YEARS OLD:

Have you had the recent Influenza Vaccine:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had the Pneumococcal Vaccine:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____
Have you ever had a Bone Density Scan:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____

HOW DID YOU HEAR ABOUT US?

☐ Family/ Friends ☐ Online booking ☐ Google ☐ Signage ☐ Other: _____