**PATIENT INFORMATION**

Could you please assist us by completing the following.

**Your Details:**

**Title \_\_\_\_\_\_\_First Name Surname Preferred Name**

**Address**

**Date of Birth \_\_\_/\_\_\_/\_\_\_\_ Male Female**

**Home Telephone Work Phone Mobile**

**Email**

 **Next of kin contact :**

Name Relationship to you Phone

**Emergency contact :**

Name Relationship to you Phone

**Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds- do you identify as someone from a culturally and/or linguistic diverse background?** Yes- Please elaborate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To assist with health initiatives- are you Aboriginal or Torres Strait Islander origin? NO

 Yes- Aboriginal Yes- Torres Strait Islander

 Yes- Aboriginal & Torres Strait Islander

Country of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Language Spoken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Medicare Number & Ref | #: | Expiry: |
| 🞏 DVA Gold 🞏 DVA White (Please tick which) | #: | Expiry: |
| Pension Number | #: | Expiry: |
| Health Care Card Number | #: | Expiry: |

I hereby give permission to Doctors@Wellington Point to receive and supply personal medical information from or to other medical practitioners/ specialist/ pathology/ radiology on my behalf.

I understand that I am required to give at least two hours’ notice when cancelling appointments.

I acknowledge that I am responsible to arrange any further appointments to discuss test results conducted by my doctor at all times.

I give permission to be notified by either letter or phone for all routine recalls and reminders.

I give consent to access the Pap Smear Register & Diabetes Register.

**HIC Online for Eligible Bulk Bill Patients:**

**I hereby authorise Doctors@Wellington Point to process my claim through Medicare Australia**

**Signed by or on behalf of the above listed patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dated: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ Please turn over**

**Your Health History -** Do you have or had a history of? (please circle)

Asthma Diabetes Hypertension Chronic illness

**Operations (Including Year)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Yes **(If yes please list below and give details of reaction)** No

**PATIENT INFORMATION**

**Current Medications and Doses** (including over the counter medications, vitamins and minerals) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children's Immunizations -** If **completing** this form for child are their immunizations up to date?

 Yes No

**Family History -** Have any members of your family had?

Diabetes

Asthma

Heart Disease

Mental illness

Cancer

**Social History**

Tobacco: day / week or Ceased Smoking - date

Alcohol: day / week / month (circle the one applicable)

Drug use: (type & frequency)

 **Height:** \_\_\_\_\_\_\_\_\_\_cm **Weight:** \_\_\_\_\_\_\_kg

**Blood Pressure:** When was the last time your blood pressure was taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sun Protection:** How often do you use the following to protect yourself from the sun when outdoors?

 **Always Often Sometimes Rarely Never**

**Protective clothing**

Sunscreen creams

**For those 65 years and older:** When was the last time you were immunized?

Influenza Date not sure never

Pneumococcal pneumonia Date not sure never

**Females:** When did you last have?

Pap smear Date: \_\_\_\_\_\_\_\_\_\_\_ not sure never

Breast Check Date: \_\_\_\_\_\_\_\_\_\_\_ not sure never

**Males:** When did you last have?

An overall checkup Date\_\_\_\_\_\_\_\_\_\_ not sure never