NEW PATIENT REGISTRATION FORM

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other ……………………………………

Surname ………………………………………………………………… **First Name** …………………………………………………………………..

Date of Birth …………/…………/…………………………

Postal address …….

………………………………………………………………… **Suburb** ……………………………………………………… **Postcode** ……………………

Daytime phone ………………………………………… **Mobile** ……………………………………… **Work** ………………………………………

Email address ………

Emergency contact person …………………………………………… **Relationship to patient** ……………………………………………

Mobile number……………………………………………………….**Daytime phone** ……………………………………………………………………

☐ As Above

Next of kin ………………………………………………………………… **Relationship to patient** ………………………………………………

Mobile number……………………………………………………….**Daytime phone** ……………………………………………………………………

Ethnicity: ☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ ……………………………………………..

Medicare number ……………………………………………… **or DVA number** …………………………………………………

Reference number (next to name) …………… **Card expiry** …………/……………

Pension or Centrelink Health Care Card Number …………………………………………… **Card expiry** …………/………

Full time student card number ………………………………………… **Card expiry**………………/……...

To whom should the account be addressed if the patient is a child:

Name …… **DOB** ………………/………………/……………

How did you hear about us?

☐ Google ☐ Facebook ☐ Family/friend recommendation ☐ Other …………………………………………………………………..

Please hand this page to Reception. Pages 2 and 3 can be given to your doctor.

MEDICAL INFORMATION

PATIENT NAME: ………………………………………………………………………………………. **DOB** ……………../……………../……………..

ALLERGIES ☐ **Nil known**

ALLERGY/INTOLERANCES	REACTION	SEVERITY

PLEASE TICK ANY RELEVANT PAST MEDICAL / SURGICAL HISTORY

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Cancer
- ☐ Migraine
- ☐ Stroke
- ☐ Blood clots
- ☐ Asthma
- ☐ Stomach or duodenal ulcer
- ☐ Epilepsy
- ☐ Depression / Anxiety

Other illness/surgery – please give details …………………………………………………………………………………………….............

Please list current medications, including vitamins and mineral supplements

NAME	DOSE

NAME	DOSE

IMMUNISATIONS

☐ Pneumococcal (pneumonia) ☐ Influenza ☐ Tetanus ☐ Childhood vaccines up to date

☐ Other (please specify) ………..............

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MEDICAL INFORMATION

PATIENT NAME: ………………………………………………………………………………………. **DOB** ………………/………………/………………

FAMILY HISTORY

	QUESTION	YES	NO
1.	**Have any of your close relatives had heart disease before 60 years of age?** *Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery.*		
2.	**Have any of your close relatives had diabetes?** *Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes.*		
3.	**Do you have any close relatives who had melanoma?**		
4.	**Have any of your close relatives had bowel cancer before 55 years of age?**		
5.	**Do you have more than one relative on the same side of the family who had bowel cancer at any age?** *Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.*		
6.	**Have any of your close male relatives had prostate cancer before 60 years of age?**		
7.	**Have any of your close female relatives had ovarian cancer?**		
8.	**Have any of your close relatives had breast cancer before 50 years of age?**		
9.	**Do you have more than one relative on the same side of your family who has had breast cancer at any age?** *Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.**		
10.	**Is there a history of mood disorder in your immediate family?**		

If there is a family history of cancer, please specify what kind: ……………………………………………………………………………..

LIFESTYLE HEALTH HISTORY (specify approximate month/year)

Smoking history:-

☐ Never smoked
☐ Former smoker, quit date …………/…………..
☐ Current smoker ……………../day
Number of years smoking ………………………..

Alcohol:-

Do you drink alcohol? ☐ yes ☐ no
Drinks per day ………………….
Drinks per week ………………….

WOMEN'S HEALTH Last pap smear date ………………/……………. Last mammogram date ………………/……………

MEN'S HEALTH Last prostate check (if aged over 40) ……………………

INFANT PROFILE

Please list any problems during pregnancy ……………………………………………………………………………………………………
When was the baby born? ☐ Full Term ☐ Premature – how many weeks? ………………………………
Mode of delivery ☐ Normal ☐ Caesarean ☐ Forceps ☐ Vacuum extraction
Please list any health problems for the baby after birth ………………………………………………………………………………
Feeding: ☐ Bottle ☐ Breast fed
Are there any smokers in the household? ☐ yes ☐ no