South Wangaratta Medical Centre & Docker Street General Medical Centre

Patient Registration Form 2021 (PAGE ONE)

PERSONAL DETAILS		
First Name:	**Last Name:**	**Preferred Name:**
Title: Mr Mrs Ms Miss Dr	**Gender:** Female Male Other	**Date of Birth:** ____/____/_____
Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Reference Number:** ___	**Expiry Date:** ____/_____

Concession Card Details:

Health Care **Pension** **Veteran (Gold)** **Veteran (White)** **Commonwealth Seniors Card**

Card Number: _____ **Expiry:** _____/_____/_____

Occupation:	**Cultural Background:** Aboriginal ☐ Torres Strait Islander ☐ Neither ☐
Is English your first language? Yes ☐ No ☐	**Country of Birth:**
If not, do you require an interpreter? Yes ☐ No ☐	**Please Specify Language:**

ADDRESSES		
Home Address:		
Town/Suburb:	**State:**	**Postcode:**
Postal Address: (if different from above)		
Town/Suburb:	**State:**	**Postcode:**

CONTACT DETAILS		
Phone:	**Mobile:**	**Work:**
Email:		

MARITAL STATUS

Single ☐ **Married** ☐ **De-facto** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Unknown** ☐

NEXT OF KIN DETAILS	
First Name:	**Last Name:**
Phone:	**Relation to you:**

EMERGENCY CONTACT- Same as Next of Kin ☐

First Name:	**Last Name:**
Phone:	**Relation to you:**

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by SMS for appointments, procedures such as vaccinations, Pap tests and other health reviews.	**I consent to being contacted with reminders to help me maintain my health.** **Yes** ☐ **No** ☐

My Previous General Practitioner Name: _____

My Previous General Practitioner Clinic: _____

If necessary, I give permission for my Medical Information to be disclosed to: (Please specify below eg spouse, parent, child, solicitor, power of medical attorney) _____

Please do not discuss my medical condition with: _____

Messages can/cannot be left on: state (home, work, mobile number) _____

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Patient Registration Form 2021 (PAGE TWO)

We are committed to protecting the confidentiality of your personal information and health records. In signing this form, you;
1. Acknowledge that we, and our service providers, will collect your personal and health information to enable us to provide you with our health services and any related communications (for example, to manage your appointment bookings); and
2. Consent to our handling of your personal information in accordance with our Privacy Policy and health information collection and use. (attached) or ask reception staff for a copy.

Do you agree to the terms?*

I agree (Please Circle) **Signature*** _____ **Date:** ____/____/ 2021

HOW DID YOU FIND US?				
Facebook	**Google**	**Chronicle**	**Family&Friends**	**Others**

MEDICAL INFORMATION

GIVEN NAME: …… FAMILY NAME ……..…….. DOB: ……/……/……. Mobile Phone: ……

PLEASE TICK ANY RELEVANT PAST MEDICAL / SURGICAL HISTORY			
Heart diseases	High blood pressure	High cholesterol	Diabetes (Type1 or Type 2)
Epilepsy	Stroke or TIA	Blood clots	Migraine
Kidney diseases	Liver diseases	Stomach ulcer or reflux	Lung diseases
COPD	Asthma	Cancer (any type)	Arthritis (OA or RA)
Heart bypass or stent	Joint replacement	Organ transplantation	Depression or Anxiety
Other illness / surgery - Please give details:			
No significant past medical/surgical history			

PLEASE LIST CURRENT MEDICATIONS, INCLUDING VITAMINS AND MINERAL SUPPLEMENTS			
1.	2.	3.	4.
5.	6.	7.	8.

Allergies to drugs or dressings: **Nil Known**

	FAMILY HISTORY	**YES**	**NO**
1	Have any of your close relatives had heart diseases before 60 years of age?		
2	Have any of your close relatives had diabetes?		
3	Do you have any close relatives who had skin cancer?		
4	Do you have any close relatives who had bowel cancer at any age?		
5	Have any of your close relatives had breast or ovarian cancer at any age?		
6	Is there a history of mental disorders in your immediate family member?		
7	Is there a history of asthma-lung diseases in your immediate family member?		
8	If there is a family history of other diseases, please specify:		
9	No significant family history diseases		

LIFESTYLE HEALTH HISTORY (SPECIFY APPROXIMATE MONTH / YEAR)			
Tobacco	***Alcohol***	***Recreational Drug***	***Physical Exercise***
Never smoked	Never drink	Never use	Never exercise
Current smoker _____/ day	Standard drinking ____/ day	Name of drug _____	Type of exercise _____
Years of smoking _____	Standard drinking ____/ week	Current dose _____/ day/ week	_____ minutes / day / week
Quite date ____/_____	How often ≥ 6 standard drinking _____ / week ___ on one occasion _____/ week	Years of usage _____	Years of exercise _____
	Are you concerned	Quit data ____/_____	
	Quit date ____/____	Rehabilitation program ___/___	

IMMUNISATIONS			
Influenza	COVID-19	Pneumococcal	Child vaccine up to date
Hepatitis B	Shingles (herpes zoster)	HPV completed	Tentanus in the past 10 years
Other Vaccines (Please specify):			

BOWEL CANCER SCREENING (IF RELEVANT)
≥ 50 years old National Bowel Screen completed: **Yes / No**
If yes, when was the last test: _____/_____

WOMEN'S HEALTH (IF RELEVANT)	
Last cervical screening date _____/_____	Last mammogram date _____/_____

MEN'S HEALTH (IF RELEVANT)	
Last overall check-up: _____/_____	Last prostate check _____/_____

INFANT PROFILE (IF RELEVANT)			
Any problems during pregnancy (Please specify):			
Full term	Normal delivery	How many weeks when baby was born:	
Premature	Caesarean	Forceps	Vacuum extraction
Any health problems after birth (Please specify):			
Breast feeding		Bottle feeding	