Nambour Clinic Family Medicine

New Patient Details Form

Date of initial consultation: ____ / ____ / ______

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other:		
Last Name:		Date of Birth:
First Name:	Middle Name:	Gender:

The following information will assist us in the planning and provision of the best possible care:

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander

What is your cultural background?

Country of Birth: Is English your first language? ☐ Yes ☐ No

If English is not your first language, do you require an interpreter? ☐ Yes ☐ No Language:

Street Address:	Postcode:
Postal Address:	Postcode:
Phone Numbers: Home Mobile Work	
Email:	
Occupation:	☐ Retired
Can we leave a message on your messagebank and/or send SMS to your mobile regarding appointments, recalls and reminders?	☐ Yes ☐ No

Medicare Card No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: ___	Expiry Date:
☐ Health Care Card **or** ☐ Pension Card No:	Expiry Date:
☐ DVA Card No: Expiry Date:	☐ Gold ☐ White

NEXT OF KIN	First name:	Surname:	Relationship:
	Address:		Phone Numbers:
EMERGENCY CONTACT	First name:	Surname:	Relationship:
	Address:		Phone Numbers:

How did you hear about this practice? (ok to tick more than one box)

☐ Yellow Pages ☐ Yellow Pages Online ☐ Doctor ☐ Newspaper/Weekly ☐ Facebook ☐ Google Search

☐ Employer ☐ Friends or Family ☐ Passing By ☐ Signage ☐ Other: ______________________________

Previous GP:	**Location:**

Privacy Statement:

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment (Enhancing Privacy Protection) Act 2012. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

Please tick:

☐ I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE

Signature: **Date:**

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Name:	**Date of Birth:**

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Smoking: ☐ Non-smoker ☐ Smoker – how many/day:___ ☐ Ex-smoker – Year started:____ Year stopped:____ ☐

Alcohol: ☐ Non-drinker ☐ Drinker – how many days/week:_____ How many std drinks/day:________ ☐

Past Drinker ☐ No ☐ Yes: ☐ Occasional ☐ Moderate ☐ Heavy Year started:___ year stopped:___

What is your weight?	**What is your height?**

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Please list any medications that you are currently taking (including vitamins and herbal medicines:

Name of medication: ________________________________ Strength: _______ Daily Dose: __________

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Have you had any immunisations recently? ☐ Flu Vaccine ☐ Pneumococcal Vaccine ☐ Other - please state: ________________________________ ☐

If child – are all childhood immunisations up-to-date? ☐ Yes ☐ No – please give details:

Do you have any significant past medical or surgical history? ☐ No ☐ Yes – please list: ____________________

____ ☐

____

Do you have any known allergies? ☐ No ☐ Yes – please list: ________________________________ ☐

____

Have you ever had an allergic reaction? ☐ No ☐ Yes – please give details: __________________________ ☐

____

Do you have any significant family history?	☐ Don't know	☐ No	☐ Yes – please complete details below:
☐ Diabetes	☐ Type 1	☐ Type 2	☐ Family member:
☐ Cancer	Type of cancer:		☐ Family member:
☐ Heart Disease	☐ Family member:		
☐ Hypertension	☐ Family member:		
☐ Stroke	☐ Family member:		
☐ Depression	☐ Family member:		
☐ Other	Condition:		☐ Family member:
Mother – alive?	☐ Yes ☐ No –	Age at death:	Cause of death:
Father – alive?	☐ Yes ☐ No –	Age at death:	Cause of death:

☐ ☐ ☐

What recreational activities do you participate in? ________________________________ ☐

____ **Elite athlete?** ☐ Yes ☐ No ☐

Marital Status:	**Do you have a carer?** ☐ Yes ☐ No	**Are you a carer for someone else?** ☐ Yes ☐ No

☐

Accommodation: ☐ Own home ☐ Nursing Home ☐ Other: __________ ☐

Lives with: ☐ Alone ☐ Spouse ☐ Friend ☐ Relative: __________ ☐

 Office Use Only: *☐ Checked* *Initials: ____*