Nambour Clinic Family Medicine
Palmwoods Clinic Family Medicine
Woombye 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

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:

Previous GP:	**Location:**

I am aware that Nambour Clinic Family Medicine uses electronic reminders (email / messages / sms) for the purposes of (but not limited to) appointment reminders, clinical reminders, clinical communications and health awareness and that ***I must advise clinic staff*** *that I choose to* ***OPT OUT*** *of this service* ***if I do not wish to receive electronic communications****.*

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. In the case that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that SMS and phone communications will be directed to that number.

Privacy Statement: *To view a full copy of our Privacy Policy please ask at reception*

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:**

Parent/Guardian to sign if patient is under 16 years of age

Name:	**Date of Birth:**

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?**

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

Name of medication: _____ Strength: _____ Daily Dose: _____

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Name of medication: _____ Strength: _____ Daily Dose: _____

Name of medication: Strength: Daily Dose:

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: _____