NEW PATIENT FORM

CONTACT INFORMATION

Gender (please circle): Male / Female / Other: .....

Title (please circle): Mr / Mrs / Ms / Master / Miss / Other: .....

Surname: ..... First Name .....

Middle Name ..... Date of Birth: .....

Street Address: .....

Postal Address (if different to above): .....

Home Phone: ..... Work phone: .....

Mobile Phone: ..... Email: .....

NEXT OF KIN CONTACT DETAILS

First name: ..... Last name: .....

Home Phone: ..... Mobile: ..... Relationship to you: .....

EMERGENCY CONTACT DETAILS (if different to NOK):

First name: ..... Last name: .....

Home Phone: ..... Mobile: ..... Relationship to you: .....

HEALTH INDENTIFIERS:

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Ref (# next to your name): _ Expiry: _ _ / _ _ _

Concession Card #: _ _ _ _ _ _ _ _ _ _ Expiry: _ _ / _ _ / _ _ _ _ PI Circle: Pension / Health Care Card

Dept of Veterans Affairs Number: _ _ _ _ _ _ _ Expiry: _ _ / _ _ _ _ Colour (please circle): Gold / White

CULTURAL IDENTITY (to assist with health initiatives):

Are you Aboriginal or Torres Strait Islander (PI circle): No / Yes, Aboriginal / Yes, Torres Strait Islander

If answered yes to above , are you registered for "Closing the gap" Yes / No

ETHNICITY (please circle) Australian / Scottish / Indian / English / Other (please specify) .....

Country of birth: ..... Language Spoken at Home: .....

PRIVACY CONSENT: Perth GP maintains confidentiality at all times. Our practice recognizes that the information we collect is often of a highly sensitive nature and as a medical centre we have adopted the highest privacy compliance standard relevant to ensure personal information is protected.

I, ..., give permission for my personal health information to be collected, used and disclosed at the discretion of the practice for the following purpose/s. I also understand that I am free to withdraw, alter or restrict my consent at any time by notifying the practice in writing.

☐ **I consent to ALL of the following** , OR (please tick all the apply below):

☐ Pathology ☐ Radiology ☐ Pharmacy Enquires
☐ Health Check Recalls ☐ Specialist Referrals ☐ Medicare (incl Billing) / HIC

NEW PATIENTS TO PERTH GP WILL NOT BE PRESCRIBED:
VALIUM, OXYNORM, OXYCONTIN, OXYCODONE OR SCHEDULE 8 DRUGS

Patient Name (please print): .....

Patient/Guardian Signature: ..... **Date:** .....

Please turn over and fill in back of page...

Patient Health History

PATIENT NAME: _____

Your Health Information

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

☐ No ☐ Unsure

☐ Yes – provide details: _____

CURRENT MEDICATIONS – Please list all of your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

_____

_____

_____

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Other – provide details: _____

_____

IMMUNISATIONS – Have you had any of the following immunisations?

☐ Tetanus Booster ☐ Hepatitis B ☐ Hepatitis A ☐ Influenza ☐ Polio ☐ Shingles ☐ Pneumonia

CHILDREN'S IMMUNISATIONS – If you are completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No ☐ Unsure

FEMALES – When did you have your last;

Pap smear? ☐ Never ☐ 1-2- Years ☐ 2-4 Years ☐ More than 4 Years

Breast check? ☐ Never ☐ 1-2- Years ☐ 2-4 Years ☐ More than 4 Years

MALES – When did you last have a;

Prostate exam? ☐ Never ☐ 1-2- Years ☐ 2-4 Years ☐ More than 4 Years

LIFESTYLE RISK FACTOR INFORMATION

Smoking

☐ No

☐ Ceased – date_____

☐ Yes – how many ___ day / ___ week

Alcohol

☐ No

☐ Yes – how many ___ day / ___ week / ___ month

Recreational Drug Use

☐ No

☐ Yes - Type_____ Frequency _____

Family Health History Information

Does any member of your family have:

☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Hypertension (high blood pressure) ☐ Mental Illness

☐ Cancer – type: _____ ☐ Other significant - provide details:

_____