Plantagenet Medical

# NEW PATIENT REGISTRATION FORM

Please show the receptionist your Medicare card and any Centrelink and/or Veterans Affairs gold cards

| | | |
|---|---|---|
| Title: | Name: | Male ☐ Female ☐ Unspecified ☐ |
| Surname: | | Preferred Name: |
| Date of Birth: | Marital Status: | Country of Birth: |
| | | Cultural Belonging: |
| Are you Aboriginal or Torres Strait Islander? | Aboriginal ☐ Torres Strait Islander ☐ | No ☐ |
| Preferred Language: | Interpreter Require Yes ☐ | No ☐ |
| Street Address: | | |
| Postal Address (if different to above): | | |
| Home: | Mobile: | Work: |
| Email: | | |
| Occupation: | | |

| | | | |
|---|---|---|---|
| Do you consent to SMS appointment reminders, result notification and correspondence? ☐ Yes ☐ No<br>*Health alert emails may be sent to you periodically - you may unsubscribe if you wish.* | | | |
| How did you hear about Plantagenet Medical? | ☐ Friend | ☐ Newspaper ☐ Internet | ☐ Other |

| Next of Kin | | |
|---|---|---|
| Name: | DOB: | Relationship: |
| Home phone: | Mobile: | |

| Emergency Contact Details (if different to above) | | |
|---|---|---|
| Name: | DOB: | Relationship: |
| Home phone: | Mobile: | |

**Consent**

☐ I consent to the disclosure and/or use of my personal health information by Plantagenet Medical and other health providers directly or indirectly involved in my personal health care or medical treatment.

Signed:_____ Date: _____

A copy of our Personal Health Information (Privacy) Policy is available on request.
Your personal information is kept private and secure, as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with GP.

**PTO**

Plantagenet Medical

# MEDICAL INFORMATION

**Patient Name:** _____ **Date of Birth:** _____

## Medical history (please tick)

- ☐Heart Disease
- ☐Lung Disease
- ☐Diabetes
- ☐Arthritis
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Depression
- ☐Cancer
- ☐Stroke
- ☐GORD
- ☐Asthma
- ☐Back Pain
- ☐Mental Health
- ☐Seizures/Blackouts/Epilepsy
- ☐Prostate Problems
- ☐Gynaecology Problems
- ☐Sleep Apnoea
- ☐Auto Immune Disease
- ☐Behavioural Issues
- ☐Other

## Family history (please tick and list family members)

- ☐Diabetes _____
- ☐Heart Disease _____
- ☐Stroke _____
- ☐Asthma _____
- ☐Cancer _____
  Type (if known) _____

## Please list any medications (including vitamins)

_____

_____

_____

_____

_____

_____

## Allergies

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

☐ No known allergies

## Smoking history

oNever

oFormer smoker –

quit date_____

oCurrent smoker_____per day

## Alcohol

| | | | |
|---|---|---|---|
| How often do you have a drink of alcohol? | ☐Never | ☐Monthly or less | ☐2-4 times a month |
| | ☐2-3 times a week | ☐4 or more a week | |
| How many standard drinks containing alcohol do you have on a typical day? | ☐1 or 2 | ☐3 or 4 | ☐5 or 6 |
| | ☐7 to 9 | ☐10 or more | |
| How often do you have six or more drinks on one occasion? | ☐Never | ☐Less than monthly | ☐Monthly |
| | ☐Weekly | ☐Daily or almost daily | |

## Immunisations (please tick which vaccines are up to date)

☐Pneumococcal (pneumonia) - Date received: _____ ☐Influenza - Date received: _____

☐Tetanus - Date received:_____ ☐Childhood vaccines - Date received: _____

☐Other (please specify)_____Date received:_____

## Gender related health history (specify approx month/year)

Last pap smear_____Last mammogram (if aged over 50)_____

Last prostate check (if aged over 40)_____

Signed: _____ Date: _____

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