HealthAbove Medical Clinic

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New Patient Form

Title Mr.____Dr.____ Mrs___ Ms.___ Miss ____Master____ Other_____

Surname _____ **First Name** _____**Preferred Name** _____

Date of Birth _____/_____/_____ **Birth Sex** _____ **Gender Identity**_____

Country of Birth: Australia_____ Other _____ (name) **Language at home** _____

Cultural background: Aboriginal _____Torres Strait Islander _____ Other _____

Home Address: _____Suburb: _____ Post Code: _____

Postal Address: _____ Suburb: _____Post Code: _____

Phone: Mobile _____ _____Home _____ ____ Work _____

Email: _____

Medicare Card Card No: _____ Ref No: _____ Expiry _____

Pension Card ___ **Health Care Card** ___ Card No: _____ Expiry_____

DVA Gold Card __ **DVA White Card** ___ Card No: _____ Expiry _____

Head of Family (required for patients under 18) _____

Next of Kin Name _____Phone _____Relationship to patient _____

Emergency Contact Name _____Phone _____ Relationship to patient _____

Marital Status: _____ **Occupation:** _____ **Height :**_____cms **Weight:**_____kgs

Allergies: _____ **Reaction:** _____

Family History: Diabetes ___ Asthma___ Hypertension ___ heart disease ___ Stroke ____

Depression ___Cancer _____ (name) Other _____

Social History: Alone____ Other _____

Care for other person___ Care for yourself ____Someone cares for you ___

Alcohol: Yes ____No___ Never____ Drink ___ days per week; _____ Drinks per day

Smoke: Yes_____ No ___ Never ____ Smoke__ days per week; _____Cigarettes per day

Ex-Smoker: Yes__No__ Year started _____; Last quit attempt _____

Past Medical History/Operations/Chronic Conditions and Illnesses (include names& dates)

_____

Medications taken (please list all)**: _____**

Recent Immunisations: _____

All Patients aged above 50yo:

Have you had a bowel cancer screening test? Yes__ No__ When _____Result _____

Female Patients

When was your last cervical screening test? _____Was the result normal? Yes __No __

Previous abnormal result for cervical screening: Yes __No __

Female Patients above 50yo:

When was your last mammogram test? _____ Was the result normal? Yes __No __

Previous abnormal result for mammogram test: Yes __No __

Health Check Date:

Prostate Check _____ Bone Mineral Density Check____Other _____

Reminders & Communication Consent "Privacy Consent "

I give consent for my Patient Health Information to be provided to Health Organisations.

This clinic also uses SMS and Email for communication. I hereby consent to the following communications: Appointment Reminders, Clinical Reminders, Clinical Communications & Health Awareness

Other family members aged under 18 who consent to receive communication to the same contact number.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

I consent to the handling of my information by this practice for the purposes set above, subject to any limitations on access or disclosure that I notify this practice in writing.

Name: _____ **DOB:** ____/_____/____ **Date:** _____

Signature of Patient /Parent/Guardian: (Please circle one) _____