tanticreek
GENERAL PRACTICE

Registration form for new patients

ADMINISTRATION FORM - Please hand this page to our reception staff Date: ……

Title …… Surname ……

First name ……

Middle name ……

Your preferred name ……

Date of birth ____ /____ /_____

Male ❑ Female ❑ X ❑

Are you of Aboriginal or Torres Strait Islander origin?
Yes ❑ No ❑

Address ……

……

Suburb …… Postcode ……

*Please ensure the name printed on your Medicare card is the same name you use when attending pathology, radiology, etc. This is to ensure your results are received correctly.

Medicare Number:
❑❑❑❑ ❑❑❑❑❑ ❑
Line Number: ❑ Expiry Date: ___ /_____

……

DVA: ❑❑❑❑❑❑❑❑
❑ Gold ❑ White ❑ Orange ❑ Blue

……

Commonwealth Concession Card:
❑ Pensioner Concession Card
❑ Health Care Card
❑ Commonwealth Seniors Health Card

Card Number:
❑❑❑ ❑❑❑ ❑❑❑❑
Expiry Date: ____ /____ /_____

		Please indicate your preferred contact number (✓tick)	Can a message be left at this number?
Home Ph			Yes ❑ No ❑
Work Ph			Yes ❑ No ❑
Mobile Ph			Yes ❑ No ❑
	We prefer to send notifications of reminders and results via SMS, where appropriate. **Do you agree to receive notifications in this manner: Yes ❑ No ❑**		
Email		Can this be used to send general information that may be relevant to you? **Yes ❑ No ❑**	

Next of Kin:
Name:
Contact Number:
Relationship to you:

Emergency Contact (if different to Next of Kin):
Name:
Contact Number:
Relationship to you:

How did you hear about us?……

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CLINICAL INFORMATION - Page 1 of 2 **Please give this sheet to the Doctor or Nurse**

As a new patient, completing this form helps us get a detailed overview of your health. This form is **confidential** and will only be kept in your confidential medical record.

Name..... date of birth.....

Your **current or past health problems** *(circle any relevant known conditions)*

Skin problems or disease	Yes ❑ No ❑	High cholesterol	Yes ❑ No ❑
Leg ulcers	Yes ❑ No ❑	High blood pressure	Yes ❑ No ❑
Anaemia/low blood count	Yes ❑ No ❑	Heart disease/chest pain/ angina	Yes ❑ No ❑
Vision/ eye problems (other than need for glasses)	Yes ❑ No ❑	Diabetes/high blood sugar/ gestational diabetes	Yes ❑ No ❑
Ongoing teeth/gum problems	Yes ❑ No ❑	Liver disease/jaundice/gallstones	Yes ❑ No ❑
Asthma/COPD/breathing problems/ chronic cough	Yes ❑ No ❑	Coeliac disease/malabsorption/ Crohn's disease/Ulcerative colitis	Yes ❑ No ❑
Bladder/kidney/prostate/incontinence problems	Yes ❑ No ❑	Stomach ulcers/reflux/indigestion	Yes ❑ No ❑
Thyroid problem	Yes ❑ No ❑	Hepatitis C/HIV - AIDS	Yes ❑ No ❑
Unusual or severe infection/ meningitis Including clostridia	Yes ❑ No ❑	Head injury – recent, recurrent or with ongoing problems	Yes ❑ No ❑
Gynaecological problems (women)	Yes ❑ No ❑	Sleep apnoea/ sleep disorder	Yes ❑ No ❑
Unexplained weight loss	Yes ❑ No ❑	Seizures/epilepsy	Yes ❑ No ❑
Cancer/lymphoma/leukemia	Yes ❑ No ❑	Anxiety/depression	Yes ❑ No ❑
DVT/blood clots/bleeding disorder	Yes ❑ No ❑	Other mental health condition	Yes ❑ No ❑
Arthritis/ Lupus/autoimmune or connective tissue disease	Yes ❑ No ❑	Stroke/TIA/other brain or neurological problem	Yes ❑ No ❑
Breast disease or recent change or lump	Yes ❑ No ❑	Migraine or severe headache	Yes ❑ No ❑
Hearing loss	Yes ❑ No ❑	Blood transfusion	Yes ❑ No ❑
Operations/surgery (please list)	Yes ❑ No ❑		

Have any **family** members had any of the following? (continued over page)

High blood pressure or high cholesterol	Yes ❑ No ❑	Stroke	Yes ❑ No ❑
Heart disease (aged under 65 years)	Yes ❑ No ❑	Diabetes	Yes ❑ No ❑
Sudden cardiac death (aged under 65)	Yes ❑ No ❑	Bleeding or blood clotting disorder	Yes ❑ No ❑

PLEASE TURN OVER

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CLINICAL INFORMATION - Page 2 of 2

FAMILY HISTORY (continued)

Cancer (incl. skin cancer) Type(s):	Yes ❑ No ❑	Hereditary conditions or those detected at birth or that run in the family:	Yes ❑ No ❑
Anxiety/depression/suicide	Yes ❑ No ❑	Dementia especially young onset	Yes ❑ No ❑

Some clinical problems are more (or less) likely to occur in people of particular ethnic backgrounds. If you wish us to be aware of your ETHNIC ORIGINS, please record here: .....

Your OCCUPATION(S): .....

PHYSICAL ACTIVITY (Please CIRCLE your activity level over the last 4 weeks)

INACTIVE (1)	LIGHT (2)	MODERATE (3)	HEAVY (4)	VERY HEAVY (5)	ELITE ATHLETE

MEDICATION LIST including over-the-counter remedies and any contraception

NAME	STRENGTH	DOSES	REASON

ALLERGIES TO MEDICATION: Yes ❑ No ❑ LIST: .....

OTHER SIGNIFICANT ALLERGIES (e.g. to nuts, eggs): Yes ❑ No ❑.....

Do you smoke tobacco? Yes ❑ No ❑ If no, are you an ex-smoker? Yes ❑ No ❑
Do you smoke marijuana? Yes ❑ No ❑
Do you drink alcohol? Yes ❑ No ❑ Have you any concerns about your alcohol intake? Yes ❑ No ❑

FOR WOMEN: Date of last pap smear: ..... Any abnormal pap smears in past? Yes ❑ No ❑

(Optional) How do you identify your gender?

.....

(Optional) How do you identify your sexual orientation?

.....

(Optional) Are you intersex? Yes ❑ No ❑