NEW PATIENT FORM

MIDLAND SUPER CLINIC WILL NOT PRESCRIBE TO NEW PATIENTS: VALIUM, OXYNORM, OXYCONTIN, OXYCODONE OR SCHEDULE 8 DRUGS.

TITLE :	( ) MR ( ) MRS ( ) MASTER ( ) MS ( ) MISS
SURNAME:	
FIRST NAME:	MIDDLE NAME:
OCCUPATION:	
COUNTY OF BIRTH:	YEAR ARRIVED IN AUSTRALIA:
MARITAL STATUS:	SINGLE / MARRIED / DE FACTO / SEPARATED / DIVORCED / WIDOWED
DATE OF BIRTH:	
SEX:	( ) MALE ( ) FEMALE ( ) TRANSGENDER
ETHNICITY:	( ) ABORIGINAL ( ) TORRES STRAIT ISLANDER ( ) OTHER SPECIFY
SPOKEN/PREFERRED LANUGUAGE:	
ADDRESS LINE 1:	
ADDRESS LINE 2:	
SUBURB:	POST CODE:
POSTAL ADDRESS:	
SUBURB:	POST CODE:
HOME PHONE:	WORK PHONE:
MOBILE PHONE:	CONSENT TO SMS REMINDER: ( )
EMAIL:	
MEDICARE NUMBER:	PATIENT NUMBER:
MEDICARE EXPIRY:	
PENSION/HCC NO:	EXPIRY DATE:
PENSION CARD TYPE:	( ) PENSIONER CONCESSION CARD ( ) HEALTH CARE CARD
DVA:	( ) WHITE ( ) GOLD ( ) SPECIFIC
DVA CARD NO:	
PRIVATE HEALTH FUND:	
NEXT OF KIN FULL NAME: RELATIONSHIP:	PH NUMBER:
EMERGENCY CONTACT: RELATIONSHIP:	PH NUMBER:

YOUR HEALTH HISTORY

Do you have or had a history of –

Operations	YES ( ) NO ( )	Asthma	YES ( ) NO ( )
Diabetes	YES ( ) NO ( )	Hypertension	YES ( ) NO ( )
Chronic Illness	YES ( ) NO ( )		

Other, please state: -

_____

Allergies:

Nil known	YES ( )	NO ( )	
Medications	YES ( )	NO ( )	Reaction type _____
Food	YES ( )	NO ( )	Reaction type _____

Other, please state: -

_____

Medications:

List current medications including over the counter medication, herbal and vitamins.

Immunisations: Have you had any of the following immunisations?

Tetanus Booster	YES ( )	NO ( )	UNSURE ( )
Hepatitis B	YES ( )	NO ( )	UNSURE ( )
Hepatitis A	YES ( )	NO ( )	UNSURE ( )
Influenza	YES ( )	NO ( )	UNSURE ( )
Pneumococcal	YES ( )	NO ( )	UNSURE ( )
Polio	YES ( )	NO ( )	UNSURE ( )

Children's immunisation – if you are completing this form for a child, are their immunisations up to date?
YES ( ) NO ( ) UNSURE ( )

Family History – have any members of your family ever had?

Asthma	YES ( )	Who _____	NO ( )	UNSURE ( )
Diabetes	YES ( )	Who _____	NO ( )	UNSURE ( )
Mental Illness	YES ( )	Who _____	NO ( )	UNSURE ( )
Heart Disease	YES ( )	Who _____	NO ( )	UNSURE ( )
Cancer	YES ( )	Who _____	NO ( )	UNSURE ( )

Other, please state: _____

Females – when did you have your last

PAP	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 – have you had an overall check up lately? YES ( ) NO ( ) UNSURE ( )

Social History:

Do you currently smoke?	YES ( )	NO ( )	How many cigarette? _____ per day
Have you ever tried to quit?	YES ( )	NO ( )	Year _____
Have you ever smoked?	YE ( )	NO ( )	

Do you drink alcohol? Never ( ) Less than monthly ( ) 1-2 days per week ( ) 3-4 days per week ( )

Do you drink 6 or more standard drinks on one occasion? Never ( ) Less than monthly ( )
Monthly ( ) Weekly ( ) Daily ( )

How many standard drinks do you have on a typical day? 1 or 2 ( ) 3 or 4 ( ) 5 or 6 ( )
7 or 9 ( ) 10 or more ( )

Does your alcohol consumption concern you? YES ( ) NO ( )

DECLARATION

I understand that other patients are waiting for an available appointment and I agree that –

- If I am unable to attend my appointment I will give a minimum of **2 hours'** notice of my cancellation,
- If I do not cancel my appointment or fail to attend, I may be charged a fee for my non-attendance.

Name (print) …… Signature …… Date …/… / …