New Patient Form

MIDLAND SUPERCLINIC WILL NOT PRESCRIBE TO NEW PATIENTS: VALIUM, OXYNORM, OXYCONTIN, OXYCODONE OR SCHEDULED 8 DRUGS OR GUN LICENCE MEDICALS/RENEWALS.

Title: (cirle)	Mr	Mrs	Master	Ms	Mrs	Other
Surname:						
Firstname:			**Middle Name:**			
Occupation:						
Country of Birth:			**Year arrived in Australia:**			
Date of Birth:						
Pronouns: (circle)	She/Her/hers		He/Him/His		They/Them/Theirs	
Marital Status: (circle)	Single	Married	De Facto	Separated	Divorced	Widowed
Birth at Sex: (circle)	Male		Female		Intersex/Other	
Gender Identity: (Circle)	Male	Female	Intersex	Indeterminate	Other:	
Ethnicity (circle):	Aboriginal		Torres Strait Islander		Other:	
Spoken/Preferred Language:						
Address:						
Suburb:			**Postcode:**			
Postal Address:						
Suburb:			**Postcode:**			
Mobile Number:			**Home Phone: (08)**			
Work Phone:			**Consent to SMS Reminders:**		Yes	No
Email Address:						
Alternative email Address:						
Medicare Number:				**Patient Number**		
Medicare Expiry:						
Concession Card Number:				**Expiry Date:**		
Type of Concession: (circle)	Healthcare Card			Pension Card		
DVA: (circle)	White		Gold		Specific	
DVA Card Number:						
Private Health Fund: (circle)	Basic	Bronze	Silver		Gold	
Next of Kin Full Name: Relationship				**Phone Number:**		
Same address?	Yes			No		
Next of Kin Full Name: Relationship				**Phone Number:**		
Same address?	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: _____ Signature: _____

Date: _____

Your Health History			
Do you have or had a history of:			
Operations:	Yes	No	When:
Diabetes:	Yes	No	
Chronic Illness:	Yes	No	
Asthma:	Yes	No	
Hypertension:	Yes	No	
Other:			
Allergies:			
Medications	Yes	No	Reaction Type:
Food	Yes	No	Reaction Type:
Other	Yes	No	Reaction Type:
Any allergies:	Yes	No	
Medications you are on:			
Medications you are on:			
Medications you are on:			
Medications you are on:			
Medications you are on:			
Medications you are on:			

Immunisations:	**Have you had any of the following?**			
Tetanus Booster	Yes	No	Unsure	
Hepatitis A	Yes	No	Unsure	
Hepatitis B	Yes	No	Unsure	
Influenza	Yes	No	Unsure	
Pneumococcal	Yes	No	Unsure	
Polio	Yes	No	Unsure	
Children's Immunisation	**Are your child's immunisations up to date?**			
	Yes	No	Unsure	
Family History	**Have any members of your family ever had?**			
Asthma	Yes	No	Unsure	Who?
Diabetes	Yes	No	Unsure	Who?
Mental Illness	Yes	No	Unsure	Who?
Heart Disease	Yes	No	Unsure	Who?
Cancer	Yes	No	Unsure	Who?
Other:				
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 checkup lately?**			
	Yes	No	Unsure	When:
Social History				
Do you currently smoke?	Yes	No	How many cigarettes a day?	
Have you ever tried to quit?	Yes	No	If yes, what year:	
Have you ever smoked?	Yes	No		
Do you drink alcohol?	Never	Less than monthly	1-2 days per week	3-4 days per week
6 or more on one occasion?	Never	Monthly	Weekly	Daily
How many on a typical day?	1-2	3-4	5-6	7-9 / 10 or more
Does your consumption concern you?	Yes		No	