**We are committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate. Please assist us by completing the following. Please note there are certain medical examinations that we are unable to bill Medicare for. There will be a fee payable for Pre-Employment Medical Examinations, Commercial Drivers Medical and other employment-based medicals.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Title:** | [ ]  Mr | [ ]  Mrs | [ ]  Ms | [ ]  Miss | [ ]  Mast | [ ]  Dr | [ ]  Prof |
| **Surname:** |  | **First Name:** |  |
| **Preferred Name:** |  | **Date of Birth:** |  |
| **Marital Status:** |  | **Gender at Birth:** | [ ]  Male [ ]  Female |
|  |  | **Gender Identity:** |  |
|  |
| **Are you of, or associate as being of Aboriginal or Torres Strait Islander Origin?** |
| [ ]  Yes - Aboriginal | [ ]  Yes – Torres Strait Islander | [ ]  Yes - Both | [ ]  No |
|  |  |  |  |
| **Street Address:** |  |
| **Suburb:** |  | **Post Code:** |  |
| **Postal Address:****(if different to above)** |  |  |  |
| **Suburb:** |  | **Post Code:** |  |
| **Home Phone:** |  | **Work Phone:** |  |
| **Mobile:** |  |  |  |
| **Email Address:** |  |
| **Preferred Mode of Contact** | [ ]  Home | [ ]  Mobile | [ ]  Email | [ ]  Letter |
| **Do you consent to SMS Reminders?** | [ ]  Yes | [ ]  No |  |  |
|  |  |  |  |  |
| **Medicare Card No:** |  | **Reference No:** |  | **Expiry Date:** |  |
| **DVA Card No:** |  | **[ ]  Gold** | **[ ]  White (condition)** |  |
| **Pension Card No:** |  | **Expiry Date:** |  |
| **Health Care Card No:** |  | **Expiry Date:** |  |
|  |  |  |  |
| **Next of Kin:** |  | **Relationship:** |  | **Phone:** |  |
| **Emergency Contact:** |  | **Relationship:** |  | **Phone:** |  |
|  |  |  |  |  |  |
| **Your Health History** |  |  |  |  |
| **Childhood Immunisation up to date** | **[ ]  Yes** | **[ ]  No** |  |  |
| **Please list any allergies including to medication, food or dressings** |
|  |
|  |
|  |
|  |
| **Please list any health problems including past operations (please include year), mental illness, chronic illness:** |
|  |
|  |
|  |
|  |
| **Please list any current medication (including over the counter meds such as vitamins and minerals)** |
|  |
|  |
|  |
|  |
| **Date of last Pap Smear (females only):** |  |  |  |  |
|  |  |  |  |  |
| **Family History** |  |  |  |  |
| **Mother** | **[ ]  Alive** | **[ ]  Passed Away** | **Father** | **[ ]  Alive** | **[ ]  Passed Away** |
| **[ ]  Diabetes** | **[ ]  Asthma** |  | **[ ]  Diabetes** | **[ ]  Asthma** |  |
| **[ ]  Heart Disease** | **[ ]  Stroke** |  | **[ ]  Heart Disease** | **[ ]  Stroke** |  |
| **[ ]  High Blood Pressure** |  | **[ ]  High Blood Pressure** |  |
| **[ ]  Cancer** | **Type:** |  | **[ ]  Cancer** | **Type:** |  |
| **[ ]  Mental Illness / Depression** |  | **[ ]  Mental Illness / Depression** |  |
| **[ ]  Other** |  | **[ ]  Other** |  |
|  |
|  |
| **Social and Lifestyle History** |
| **Recreational Activities / Exercises:** |  |
| **Accommodation:** | **[ ]  Own home** | **[ ]  Hostel** | **[ ]  Nursing Home** | **[ ]  Rental** | **[ ]  Other** |
| **Lives with:** | **[ ]  Spouse / Partner** | **[ ]  Relative** | **[ ]  Friend** | **[ ]  Alone** |
| **Do you have a Carer?** | **[ ]  Yes** | **[ ]  No** | **Are you a Carer?** | **[ ]  Yes** | **[ ]  No** |
| **Occupation:** |  | **Retired?** | **[ ]  Yes** | **[ ]  No** |
|  |  |  |  |  |
| **Alcohol Intake:** | **[ ]  Drinker** | **[ ]  Non-Drinker** | **[ ]  Past Drinker** |
| **Days per week:** |  | **Drinks per day:** |  |
|  |  |  |  |
| **Tobacco Intake:** | **[ ]  Smoker** | **[ ]  Ex-Smoker** | **[ ]  Non-Smoker** |
| **Year Started:** |  | **Cigarettes per day:** |  | **Year stopped:** |  |
|  |  |  |  |
| **[ ]  I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.** |
| **Print Name:** |  | **Date:** |  |