CORRIE ST MEDICAL CLINIC CHERMSIDE

New Patient Information Sheet

Please fill out **ALL** of the form to ensure we can provide the best possible care available.

Surname:	Title: ☐ Mr ☐ Mrs ☐ Dr ☐ Miss ☐ Ms
First Name:	Middle Name:
Known As:	☐ Single ☐ Married ☐ De Facto ☐ Divorced
DOB:	
Residential Address:	
Mailing Address:	
E-mail Address:	
Phone No:	**Mobile:**
Medicare Card No:	Ref: Expiry:
Concession Card HCC/Pension/Seniors/DVA : No:	Expiry:

Occupation:	**Employer**:
Address:	Phone No:

Next of Kin:	Relationship:
Phone No:	
Emergency Contact - ***different from above***:	Relationship:
Phone No:	

Country of Birth:	**Primary Language:**
Please advise if an Interpreter is required	
Do you **identify** as: ☐ Aboriginal ☐Torres Strait Islander ☐ Both ☐Neither	
If **Yes** (ATSI) are you registered for the "Close the Gap" program: ☐Yes ☐No	
Cultural needs or Religious Beliefs:	

Children Under 16 need to have an adult as the Primary Account Holder as Medicare will not accept claims for children	
Please indicate who is the **Legal Guardian**: ☐ NOK ☐ Emergency Contact	
Is the **Legal Guardian** a patient at this Practice: ☐ Yes ☐ No	
If **No** please give details: Name:	DOB:
Medicare No:	Ref: Expiry:

Reminder Systems: Would you like a SMS message sent to remind you of a scheduled appointment or paperwork to be picked up?	☐ **Yes** ☐ **No**
Recall Systems: Would you like to be included in our disease prevention Register?	☐ **Yes** ☐ **No**
Privacy Policy: Would you like a copy of our Privacy Policy?	☐ **Yes** ☐ **No**

Your health and family history – do you have or have you had a history of?
(Please include any family history as well)

Your History

□ Operations □ Asthma □ Diabetes □ Hypertension □ Chronic Illness □ Other

Please give details_____

_____

_____

Your Family History

□ Operations □ Asthma □ Diabetes □ Hypertension □ Chronic Illness □ Other

Please give details_____

_____

Do you have any allergies or are you sensitive to drugs or dressings?
Yes □ No □ (If Yes please list):

Current Medications (including over the counter medications, vitamins and minerals):

Social History:
Tobacco use: _____ day/week or ceased smoking – date _____
Alcohol: _____ day / week / month (please circle)
Drug use: (type and frequency)
(Office Use Only)
Height _____ cms **Weight:** _____ kgs **Blood pressure**_____
Blood Pressure: when was your blood pressure taken last? _____

For those 65 years and older: when was the last time you were immunised?

Influenza	Date _____	□ Not sure	□ Never
Pneumococcal pneumonia	Date _____	□ Not sure	□ Never

Females: When did you last have?
Pap smear - Date _____ □ Not sure □ Never **Breast check** - Date _____ □ Not sure □ Never

Males: When did you last have an overall check-up? Date _____ □ Not sure □ Never

Please complete this section:

Patient Name: **Date of Birth:**

Patient Signature: **Date:**