

New Patient Information
ARANA HILLS MEDICAL CENTRE

NAME of patient attending today:

Miss / Mrs/ Ms /Mr/ Dr

Date of Birth _____

Gender: Male Female Other

Marital Status: Married/De-facto Single

Separated Divorced Widowed

Home Address _____

Suburb _____ Post Code _____

Country of Birth _____

Ethnicity _____

Do you identify as Aboriginal or Torres Strait Islander?

Aboriginal Torres Strait Islander Both

Mobile Phone _____

Home Phone: _____

Work Phone: _____

Email address: _____

Medicare Number: _____

Reference: _____ **Expiry Date** _____ / _____

Are you a Pensioner? Yes No

Health Care Card? Yes No

Seniors Health Card? Yes No

Veterans Affairs Gold? Yes No

Veterans Affairs White? Yes No

Entitlement No: _____

Expiry _____ / _____ / _____

Do you have private health insurance? Yes No

Which Fund? _____

Person responsible for accounts should complete here:

Surname: _____

Given Name: _____

DOB: _____

Next of Kin: _____

Relationship: _____

Phone Number: _____

Emergency Contact: _____

Relationship: _____

Phone number: _____

Your Occupation: _____

I, _____ give consent for my doctor to use my personal information to contact me regarding matters regarding my health or that of my dependants. *

Signature of Patient / Parent or Guardian

Date: _____

*In accord with National Privacy Policy, the information collected on this form will be kept strictly confidential and will be accessible only by authorised staff and Doctors. Please refer to the Privacy Policy brochure available from reception. This information may be used to contact you, or members of your family, for the purposes of informing the results of tests and investigations or to ensure follow up of unresolved problems. In addition, you may be contacted for the promotion of Preventive Health activities such as Immunisation, Cardiovascular checks, Asthma and Diabetes reviews, Well Woman examinations as well as Health Assessments for the elderly. We also support new government programs to improve these health services which involve securely submitting patient de-identified data.

Please inform reception if you wish to opt-out of this process.

Please complete for family members and dependants living at home who attend this clinic

Name	Date of Birth	Relation to patient

Patient Name _____ Date of Birth _____

Do you or any of your family have a history of– (please tick or state which family member where applicable)

CONDITION	You	Relationship	CONDITION	You	Relationship
<input type="checkbox"/> Heart Disease			<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Diabetes			<input type="checkbox"/> Stroke / Blood clots		
<input type="checkbox"/> Asthma			<input type="checkbox"/> Chronic Lung Disease		
<input type="checkbox"/> Gastro-Intestinal conditions			<input type="checkbox"/> Coeliac disease		
<input type="checkbox"/> Mental Health Issues			<input type="checkbox"/> Migraine		
<input type="checkbox"/> Chronic Kidney Disease			<input type="checkbox"/> Abdominal Aortic Aneurysm		
<input type="checkbox"/> Colon (Bowel) Cancer			<input type="checkbox"/> Prostate Cancer		
<input type="checkbox"/> Breast Cancer			<input type="checkbox"/> Melanoma		
<input type="checkbox"/> Ovarian Cancer			<input type="checkbox"/> Osteoporosis		

Have you any Allergies? YES or NO

If so, which ones and describe reaction: _____

Please list any Herbal or Vitamin supplements _____

Current Prescription Medications

<input type="checkbox"/>	<input type="checkbox"/>

Major Operations – (include year if known)

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Height: _____ cm Weight: _____ kgs

PLEASE TURN OVER FOR THE NEXT PAGE



Patient Name _____ Date of Birth _____

Non-Smoker **or** Current Smoker How many per day _____ Ex-Smoker Quit Date _____

Non-Drinker **or** Rarely drink or Current Alcohol Use: _____ Drinks per week / month (Average)

Other Recreational Substance Use

For Preventive Health Care

When did you last have? (Please List)

Healthy Heart Check: Date _____ not sure never

Skin Cancer / Mole Check: Date _____ not sure never

Bowel Cancer Check (Colonoscopy): Date _____ not sure never

Females >40yrs:

Mammogram: Date _____ not sure never

Post-Menopausal Bone Density Test: Date _____ not sure never

Obstetric History: Pregnancies Live Births Miscarriages

Males > 50yrs:

Prostate Examination or PSA Test Date _____ not sure never

Bone Mineral Density Test >70 yrs Date _____ not sure never

Marital Status: Married/De-facto Single Separated Widowed

Family History:

Mother: Alive and Well Any illness _____ Unknown Or, Age when deceased _____

Father: Alive and Well Any illness _____ Unknown Or, Age when deceased _____

Brothers: How Many? Alive and Well Any illness _____

Sisters: How Many? Alive and Well Any illness _____

Children: How Many? Alive and Well Any illness _____

Have you maintained access to My Health Record Yes No, I have opted out.

Patient's Signature Date _____

Health details entered by _____ Date _____
Doctor Signature



MUSCLE AND JOINT INJURY - QUESTIONNAIRE FOR NEW PATIENTS

NAME: _____

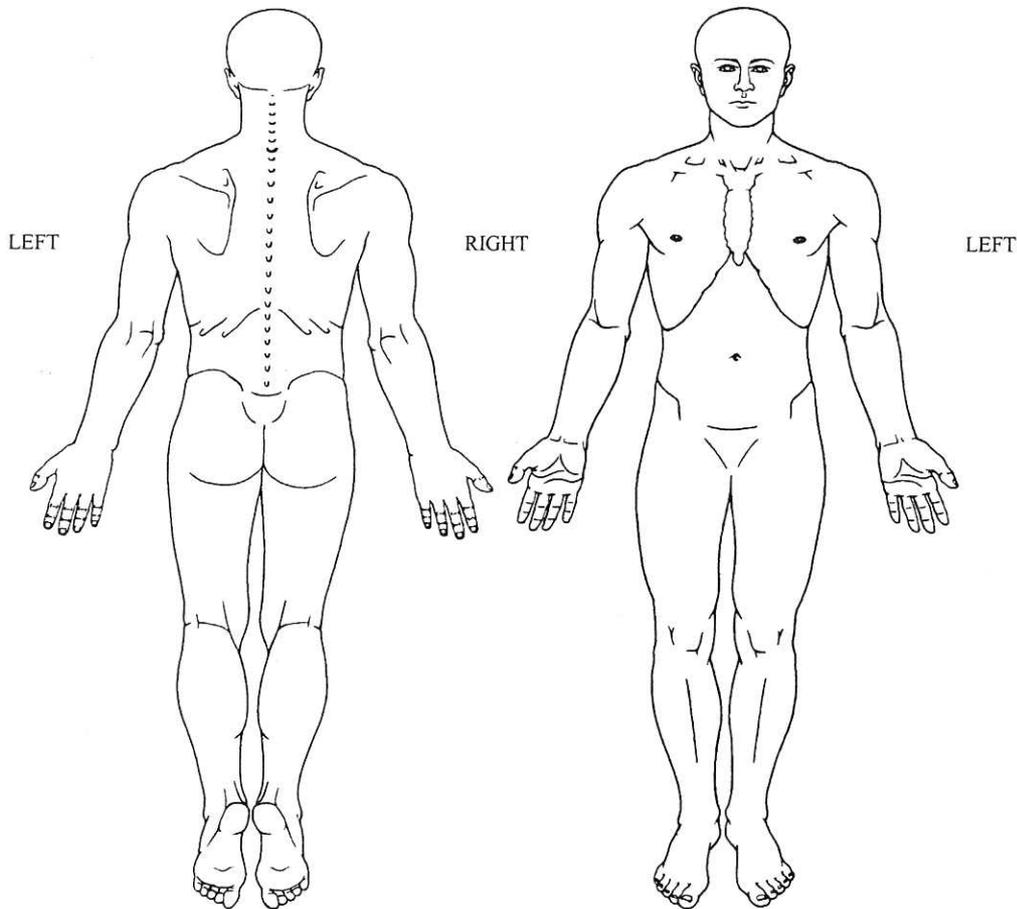
DATE: _____

SOURCE OF REFERRAL TO THIS CLINIC: _____

ABOUT YOUR PAIN

1. Please mark on the body diagram below all of the areas where you feel pain or abnormal sensations. Use the symbols below, where possible. Put a large **X** where the centre of your pain is.

PAIN	////// //////	CONSTANT	XXXXX	BURNING	----
		ACHE	XXXXX	FEELING	----
NUMBNESS	::::: :::::	PINS &	OOOOO	OTHER	SSSSS
		NEEDLES	OOOOO	SENSATION	SSSSS



For how long have you had your pain(s)? _____

2. Please circle the word or words that best describe your pain(s).

THROBBING	SHOOTING	STABBING	SHARP	CRAMPING
GNAWING	HOT/BURNING	ACHING	HEAVY	TENDER
SPLITTING	TIRING/ EXHAUSTING	SICKENING	FEARFUL	PUNISHING/ CRUEL

3. If you know what caused your pain, please describe the injury or actions that did this. If you do not know, just write "I don't know".

4. Please list any activities, movements or postures that often make your pain(s) worse.

5. Please list any activities, movements or postures that often relieve your pain(s).

6. If you suffer from joint stiffness, please write down where you feel this and how long it lasts each day.

7. If you have any numbness, tingling or weakness in your limbs, please describe it as best you can.

8. Please circle a number on the box scale, which describes **your usual level of pain in the last week**. If you have more than one pain, score each of them and label them on the scale.

NO PAIN

WORST PAIN
IMAGINABLE

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

HOW YOUR PAIN(S) AFFECTS YOUR ACTIVITIES

1. Please circle a number on the box scale, which describes how much your pain has limited your **ability to perform your usual activities in the last week**.

NO LIMITATION
OF USUAL
ACTIVITIES

COMPLETE LIMITATION
OF USUAL
ACTIVITIES

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

2. What are the four things in your life that you can't do. Or have difficulty doing, because of your pain and which most dearly you would want restored?

FOUR ACTIVITIES

i.

ii.

iii.

iv.

YOUR CONCERNS ABOUT THE PAIN

If you have any concerns about the future of your pain problem or how the pain is affecting your work or home life, please list them here.

YOUR PAST DIAGNOSES, TREATMENTS AND OTHER MEDICAL HISTORY

1. Please list :

- Any previous diagnoses you have had for your pain problem(s).

- Any treatments you have had for your pain problem(s).

- Any important medical conditions, present or past.

- Any medications you are taking (including vitamins and herbal medications)

- Allergies or reactions to medications or other treatments

- Your occupation (including home duties or voluntary work if your work is unpaid)

- The main activities, hobbies and sports that you like to do

WHAT YOU HOPE TO GET FROM YOUR VISIT TO THIS PRACTICE

1. Please tick the things that you hope to get from your visit to the pain clinic:

- Diagnosis
- A second opinion
- Treatment.

If you came for a specific treatment please indicate what you hope to receive:

- Report for Centrelink
- Legal report
- Other (please specify)