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
☐ Heart Disease			☐ High Blood Pressure		
☐ Diabetes			☐ Stroke / Blood clots		
☐ Asthma			☐ Chronic Lung Disease		
☐ Gastro-Intestinal conditions			☐ Coeliac disease		
☐ Mental Health Issues			☐ Migraine		
☐ Chronic Kidney Disease			☐ Abdominal Aortic Aneurysm		
☐ Colon (Bowel) Cancer			☐ Prostate Cancer		
☐ Breast Cancer			☐ Melanoma		
☐ Ovarian Cancer			☐ 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

○	○
○	○
○	○
○	○

Major Operations – (include year if known)

○	○
○	○

Height: _____ cm **Weight:** _____ kgs

PLEASE TURN OVER FOR THE NEXT PAGE

Arana Hills Medical Centre
Arana Hills Plaza Shopping Centre
Arana Hills Q4054

Ph: 07 33516444
Fax: 07 33516246

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. ☐

_____ **Date** _____
Patient's Signature

Health details entered by _____ **Date** _____
Doctor Signature

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