

PART A Patient Information Details All patients are asked to complete this section

Title : Mrs Mr Miss Ms Master Male Female Gender Identity: _____

Surname : _____ Given names : _____

Date of Birth : _____

Phone - Home : _____ Mobile : _____ Work : _____

Address : _____ Post code : _____

Postal Address (if different to Street) _____

Can we contact you via SMS for : appointment reminders , recalls and messages ? Yes No

Emergency Contact Person _____ Phone - Home _____

Mobile : _____ Relationship : _____

Next of Kin if Different to Emergency : _____

Phone – Home : _____ Mobile : _____ Relationship : _____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally diverse background ?

Are you of Aboriginal or Torres Strait Islander Origin ? No Yes , Aboriginal Yes , Torres Strait Islander

Please state other cultural background : _____

Privacy in Our Practice We value the doctor- patient relationship. Patient privacy is vital to such a relationship

To comply with the Australian Privacy Principles, we require your consent to collect personal information. Our doctors and staff collect information from patients primarily to provide proper care and treatment. Your information may also be used in the following ways :

- Administrative purposes in running the practice
- Billing and collection purposes
- Disclosure to other doctors , nurses , therapists and specialists outside this medical centre. This may occur through referral to other doctors, or for medical tests and in the reports of results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums and trainees attached to the practice, for the purpose patient care and teaching.
- Legal disclosure for any existing or future legal proceedings.
- You can assist in maintaining the accuracy of your information by advising the practice of changes to your personal contact details.

I consent to the handling of my information by this practice for the purpose set out above .

Signature : _____ Date : _____

How did you hear about the practice ? Website Internet Yellow pages Friend/relative Other

Do you intend to have ongoing medical care provided by Crestmead Medical Centre ? yes no

Part B Patients who will be continuing to use Crestmead Medical centre are asked to complete the following

Name _____ DOB _____

PART B Your health history - do you have or have you had a history of?

Asthma Diabetes High Blood Pressure Heart Disease

Any other Chronic Illness/ Disease _____

Past Surgical History _____

Do you have any allergies or are you sensitive to drugs or dressings:

Yes (If yes please list below) No

Immunisations - have you had the following immunisations?

Tetanus booster date _____ Don't Know Haven't had one

Children's immunisations - if completing this form for a child are their immunisations up to date?

Yes No

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

Family history - have any members of your family had:

Diabetes Asthma Heart Disease Mental illness Cancer

Social history : Occupation _____

Tobacco: _____ day / week or Ceased Smoking - date _____

Alcohol: _____ day / week / month (circle the one applicable)

Drug use: _____ (type and frequency)

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