Patient Information Form

Please complete and give **page 1 and 2 to reception** and take **pages 3 and 4 into the consultation** with you.

Personal Contact Details (Name as it appears on your Medicare Card)

Title (Please circle): **Mr** **Mrs** **Ms** **Miss** **Mast** **Other** (please specify): _____________

Family/Last Name: ____

Given Names: ______________________________ **Preferred Name:** ___________________

Date of Birth: Day ______Month _______ Year _______

Birth Sex (Please circle)**:** Male/ Female/ Other

Gender Identity: Male/ Female/ Non-binary/ Gender diverse/ Transgender/ Different identity

Pronouns : She/Her/Hers He/Him/His They/Them/Theirs

Home Address: ____

____ **Postcode:** ___________

Postal Address: ____

____ **Postcode:** ___________

Home phone number: _____________________ **Mobile Number:** ______________________

Work phone number: ______________________ **Email:** ______________________________

Ethnicity (Please circle)

Australian, non indigenous **Aboriginal but not Torres Strait Islander**

Torres Strait Islander but not Aboriginal **Both Aboriginal and Torres Strait Islander**

Other **Country of Birth:** ____

Government Identifiers

Medicare Card No.: ________________________ **IRN :** _____ **Expiry Date:** ___________

Concession Card Number: ___________________________ **Expiry Date:** ___________

Pension Card / Health Care Card / DVA Gold / /DVA White (state conditions below)

DVA White card conditions ____

Patient Information Form

Next of Kin

Name: ____

Address: ____

Phone/Mobile Number: ______________________

Relationship to Patient: _____________________

Emergency Contact Details (if different from Next of Kin)

Name: ____

Address: ____

Phone/Mobile Number: ______________________

Relationship to Patient: _____________________

Do you consent to be contacted via SMS for appointment reminders, recall and other text reminders or medical services we offer?: Y / N

Important Information

Transfer of medical records: If you have previously seen a GP at another medical practice the information held by that GP may assist us with your future healthcare needs. If you wish to have your records transferred to this surgery please advise reception.

MSMC operate a recall and reminder system. Recall – you will be contacted by reception if your doctor would like a follow-up appointment to discuss radiology/pathology test results. Reminder – when you are due for routine preventative health measures such as cervical screening, vaccinations, health checks etc you will be contacted and advised to make an appointment.

Doctors at Main Street Medical Centre on occasions are asked to participate in research for quality assurance. To enable them to do this they need permission to use de-identified medical information from the patient's medical records. This form covers the collection and use of your information to provide comprehensive, co-ordinated and continuing whole person medical care. The privacy policy outlines the way that your information may be disclosed to other health care professionals to provide this high level of care.

MSMC are committed to maintaining the confidentiality of your personal information. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised member of staff. A copy of the Practice Privacy Policy is available at reception.

Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in the manner described above.

Signature: ____________________ **Name:** ________________________ **Date:** __________

Please hand pages 1 and 2 to RECEPTION before completing pages 3 and 4

We can then add your details into the computer and let your doctor know you have arrived

Patient Information Form

Information for your doctor

Patient Name : ____

Height: ______________ **cm** **Weight:** ______________ **kg**

Occupation: ____

Children's immunisations

If completing this form for a child are their immunisations up to date? Y / N

Social History

Marital Status

Single / Married / De facto / Widowed / Divorced

Allergies

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

Y / N (if yes please list) ___________________________________

Do you smoke?:

Never smoked / Ex smoker (date quit) ______________ / Smoker (no. per day) ________

Days a week you drink alcohol: Never / Daily / 1-2 Days / 3-4 Days / 5-6 Days / Every Day

How many standard drinks per occasion? _____________

Drug Use: (type and frequency) ____

Medical History

Current or past medical conditions:

Asthma	Y / N	Diabetes	Y / N	Blood Disorders	Y / N
Epilepsy	Y / N	Depression	Y / N	Migraine	Y / N
High Cholesterol	Y / N	Blood Pressure	Y / N	Kidney Disease	Y / N
Cancer	Y / N	Arthritis	Y / N		

Other (please specify): ____

MAIN STREET MEDICAL CENTRE

Patient Information Form

Have you had any operations? (Please give details)

____

Current Medications

____

____

Family History

Have any members of your family had (if yes please specify which relative)

Asthma Y / N ____________________ Diabetes Y / N ______________________

Heart Disease Y / N ____________________ Mental Illness Y / N _____________________

Cancer Y / N ____________________

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