



NEW PATIENT FORM

Welcome to our Practice, please complete this medical history form, this document is important for you to obtain high quality health care. Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down. As you are providing us with health information please also read and sign the consent form to allow us to collect and use your health information. Thank-You.

Personal Details

First Name: _____ Surname: _____

Date of Birth: ___/___/___ Birth Sex: _____ Gender Identity: _____

Pronouns: She/Her/Hers..... He/Him/His.....They/Them/Theirs (please circle)

Address: _____

Suburb: _____ Postcode: _____

Phone Home: _____ Mobile: _____

Email: _____

Medicare number: _ _ _ _ _ Expiry _ _ / _ _ PRN No. ____

Pension number: _ _ - _ _ - _ _ Expiry ___ / ___ / _____

Do you identify as an Aboriginal/Torres Strait Islander: Yes /No **Ethnicity(Australian/English etc)** _____

Emergency contact/Next of Kin: _____ Phone: _____

Relationship to Emergency Contact/Next of Kin: _____

Current Occupation: _____ or School _____ Year _____

Previous Doctor: _____ Address: _____

Other family members attending this practice: _____

Medical History

Do you have any allergies to medicines or anything else? No Yes

To what? _____ Reaction? _____

Current medications (including over the counter medication)

Name of medication	Strength	Times taken

Have you ever had any major operations or been admitted to hospital?

Year	Reason

Preventative Health:

When was your last check for the following	Year	Year
Cholesterol		Bowel cancer
Blood Pressure		HIV test
Prostate check		Hepatitis test
Pap smear		Glaucoma

Social:

Do you.....	Yes or No	Amount	Days per week
Cigarettes			
Alcohol			
IV Drugs			
Other Drugs			
Exercise			

Have You ever had:

	Year began	Active now✓		Year began	Active now✓
Heart Problems			Serious infection		
Angina			Skin rashes, dermatitis, eczema, psoriasis		
High blood pressure			Epilepsy/fits/blackouts/strokes		
High cholesterol			Migraine		
Varicose veins, clots or blocked arteries			Asthma/emphysema		
Stomach ulcers			Hey fever/ sinus problems		
Gall stones			Eye/ ear problems		
Liver disease, Jaundice, Hepatitis			Back/neck problems		
Pancreatitis			Serious trauma		
Hernia/ bowel problems			Emotional disorder/ stress		

Rectal bleeding			Kidney / urine/ bladder problems		
Diabetes			Prostrate problems/ impotence		
Thyroid problem			Abnormal pap smear		
Gout			Sexually transmitted disease		
Arthritis/Joint problems			AIDS		
Cancer-where?			Intravenous drug use		

Family History:

Has anyone related to you ever had	Relationship to you	Ever had ✓	Age of onset	Died from ✓	Age
High blood pressure					
High cholesterol					
Heart attack/angina					
Stroke					
Anaemia					
Bleeding disorder					
Asthma /emphysema					
Tuberculosis					
Arthritis					
Diabetes					
Kidney disease					
Cancer or tumor					
Other					