50 Armstrong Street
Middle Park VIC 3206
Phone 9699 4333
Fax 9699 4330

armstrongstreetmedicalcentre.com.au

Armstrong Street
Medical Centre

New Patient Registration Form

Title: Mr / Mrs / Ms / Miss/ Master / Dr / Prof **Sex:** ☐ Male ☐ Female

First Name: _____ **Surname:** _____ **Known as:** _____

Date of Birth: ____/____/_____ **Country of Birth:** _____ **Cultural Background:** _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ __ **Reference No.** ( ) **Expiry Date:** ____/____/_____

Pension Card / HCC: Yes / No **Veteran's Affairs:** Yes / No **Veteran's Affairs Number:**_____

Are You: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

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PLEASE SELECT ONE: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Address: _____

Suburb: _____ **State:** _____ **Post Code:** _____

Home Phone Number: _____ **Work Phone Number:** _____

Mobile Number: _____ **Email Address:** _____

Occupation: _____ **Partner's Name:** _____

Next of Kin

First Name: _____ **Surname:** _____ **Known as:** _____

Phone Number: _____ **Relationship to Patient:** _____

Emergency Contact (other than person listed above):

First Name: _____ **Surname:** _____ **Known as:** _____

Home Number: _____ **Relationship to Patient:** _____

Parent / Guardian: **if patient is a *CHILD UNDER 16***

First Name: _____ **Surname:** _____ **Date of birth**____/_____/_____

Medicare Number: __ __ __ __ __ __ __ __ __ __ __ **Reference No.** ( )

How did you hear of us: ☐ Internet ☐ HealthEngine ☐ The Leader ☐ Passing By ☐ Recommendation
☐ Magazine: …… ☐ Radio: …….. Other: ……

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Consent Form

Please read this consent form carefully, and sign where indicated below.

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. We require your consent to collect your personal information, and for its use in the following ways:

- Administrative purposes.
- Billing purposes (including compliance with Medicare and Health Insurance Commission requirements).
- Disclosure to others involved in your healthcare. This includes your treating doctor and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Only information that does not identify you is used in these circumstances.
- To comply with any legislative or regulatory requirements, such as notifiable diseases.
- For reminders and recalls which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
I consent to SMS text message appointment reminders to be sent to my mobile phone.	☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient Name: …… **Date :** ...../……../20……

Patient Signature: ……..……..

Signed as Guardian for child: ……

Name of Guardian: (printed) ……

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Patient Health History Form

Allergies: Do you have any allergies or are you sensitive to drugs or dressings?
☐ No. ☐ Yes. Please elaborate:

Drug, Dressing or Substance	Reaction (eg. rash, hives, wheeze, shortness of breath, anaphylaxis)

Do you use any of the following: (list amount where appropriate)

Tobacco:
☐ Never smoked
☐ Ex-smoker (please answer questions below)
☐ Smoker (please answer questions below)
Year when you started smoking: ……
Year when you ceased smoking: …… or ☐ Currently smoking
Longest period of abstinence whilst smoking: …….. years / months / weeks / days (circle)
Frequency: ☐ Daily ☐ Weekly ☐ Less than weekly
Number of cigarettes when you do/did smoke: ……..... per day **or** ……..……..… per week

Alcohol:
☐ Never.
☐ Yes.
Frequency: ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ 1-2 days per week
☐ 3-4 days per week ☐ 5-6 days per week ☐ Daily
On a day that you drink, how many standard drinks do you have? ……
How often do you drink 6 or more standard glasses of alcohol in one day?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Other Drugs:
☐ No.
☐ Yes. Type (please circle): Cannabis / Methamphetamine / Ecstasy / LSD / Cocaine / Heroin
Other: ..... Frequency: ……...

Family History:

Have any family members had any of the following medical problems, and please elaborate:

☐ High Blood Pressure ……...
☐ High Cholesterol ……..
☐ Diabetes ……
☐ Thyroid Disease ……..
☐ Heart Disease ……..
☐ Stroke ……
☐ DVT or Lung Clots ……..
☐ Cancers ……
☐ Skin Cancer ……..
☐ Melanoma ……..
☐ Osteoporosis ……
☐ Varicose Veins ……
☐ Migraines ……..
☐ Mental Illness ……...
Other: ……
……
……

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Past Medical History:
Do you have or have you had a history of the following? (please elaborate)
☐ Operations ……..……..……..
☐ Asthma ……..……..……..
☐ Diabetes ……..……..……..
☐ High Blood Pressure ……..……..
☐ Chronic Illness ……..……..……..
☐ Other ……..……..……..

Current Medications :
Please list all current medications, doses and frequency of use including over the counter medications, vitamins and minerals: ……..
……..……..
……..……..

Females:
When did you last have?
Pap Smear: Date: ……../……../…….. ☐ Not sure ☐ Never
Breast Check: Date: ……../……../…….. ☐ Not sure ☐ Never
Mammogram: Date: ……../……../…….. ☐ Not sure ☐ Never
Bone Mineral Density Scan: Date: ……../……../…….. ☐ Not sure ☐ Never

Males:
When did you last have an Overall Checkup: Date: ……../……../…….. ☐ Not sure ☐ Never

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

Immunisations:
If completing this form for a child is their immunisations up to date? ☐ Yes ☐ No
Have you had the following immunisations? (list date where appropriate)

Tetanus Booster	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis B	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis A	☐ Yes. Date:	☐ No	☐ Don't Know
Influenza	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ Don't Know
Polio	☐ Yes. Date:	☐ No	☐ Don't Know

Sun Protection:
How often do you use the following to protect yourself from the sun when outdoors?

Protective clothing	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never
Sunscreen creams	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never

Measurements:
Height: ……. cm Weight: ……. kg What was your last blood pressure reading? ……./…….