Admin	Office Use Only
Init	☐ On-Line PV ☐ Current/ Casual ☐ Usual Dr ☐ Data Checked
Date	Init. Date:
Clinical	
Init	
Date	

PATIENT REGISTRATION & INFORMATION FORM:

We are committed to providing our patients with the best care.
To do this it is essential that your health record is kept up to date and accurate.

PART A: ALL patients are asked to complete the following.

Title:	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:
Surname:	
First Name:	**Middle Initial:**
Preferred Name:	**Date of Birth:** / /
Sex ☐ Male ☐ Female	**Gender** _____
Street Address:	
Postal Address: **(if different to street address)**	

Mobile no.	**Work no.**	**Home no.**	
Email:			
Occupation:			
Medicare Number:	**No. of person on card:**	**Exp. Date:**	
DVA Gold/ White:		**Exp. Date:**	
Pension/HCC Number:		**Exp. Date:**	
Next of kin: (Name, Address & phone number)	**Name:** **Telephone number:** **Relationship to you:**		
Emergency Contact: (If different to Next of Kin)	**Name:** **Telephone number:** **Relationship to you:**		

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 and/or linguistic diverse background?

☐ No

☐ Yes – Please elaborate_____

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander
☐ No (neither Aboriginal & Torres Strait Islander)

Do you have any allergies or are you sensitive to drugs or dressings? ☐ No
☐ Yes (please list below)

_____
_____
_____
_____
_____

PART B:

Reminder Systems -

Would you like to have appointment reminders sent via SMS?	☐ **Yes**	☐ **No**

Our practice also provides our patients with preventive care and early case detection reminders e.g.: - immunisations, annual health checks; skin checks and pap smears.

Do you offer consent to participate?

☐ Yes – Text Message
☐ Yes – Mail to my address
☐ No thank you

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

☐ Surgeries:	Details: _____ Details: _____ Details: _____ Details: _____	Date: _____ Date: _____ Date: _____ Date: _____

☐ Asthma:	☐ Yes	☐ No
☐ Diabetes/ Gestational Diabetes (in pregnant women only):	☐ Yes	☐ No
☐ Hypertension	☐ Yes	☐ No
☐ Chronic illness	☐ Yes	☐ No

☐ Other

Immunisations - have you had the following immunisations?

Tetanus booster	Date: _____	☐ Don't Know	☐ Haven't had one
Whooping cough (pertussis)	Date: _____	☐ Don't Know	☐ Haven't had one
Hepatitis A	Date: _____	☐ Don't Know	☐ Haven't had one
Hepatitis B	Date: _____	☐ Don't Know	☐ Haven't had one
Influenza	Date: _____	☐ Don't Know	☐ Haven't had one
Pneumococcal	Date: _____	☐ Don't Know	☐ Haven't had one
Polio	Date: _____	☐ Don't Know	☐ Haven't had one
Gardasil , 1	Date: _____	☐ Don't Know	☐ Haven't had one
Gardasil , 2	Date: _____	☐ Don't Know	☐ Haven't had one
Gardasil , 3	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 supplements) -

_____

_____

_____

_____

Family history - have any members of your family been diagnosed with or suffered from the following please outline details

☐ Diabetes ☐ Asthma ☐ Heart Disease ☐ Mental illness ☐ Cancer ☐ Other	**Details**

Social history –

Smoking status

Have you ever smoked? ☐ Yes ☐ No

If you have or do smoked, what year did you start? _____

If you have ceased when did you cease? _____

If you currently smoke how many per day do you smoke?_____

Alcohol consumption

☐ I do not drink

I drink _____standard drinks per day/week/month (please circle)

How often do you have more than 6 std drinks in one sitting?

_____ a day/week/month/ year/never (please circle)

Please outline any recreational drug use (type or frequency):

_____

How often do you exercise or engage in physical activity for 30 minutes or more?

☐ Daily or _____ times per Week ☐ Never ☐ Other: _____

Females: When did you last have a -

☐ Pap smear	Date_____	☐ Not sure	☐ Never
☐ Breast Check	Date_____	☐ Not sure	☐ Never
☐ Mammogram	Date_____	☐ Not sure	☐ Never

Males: When did you last have a -

An overall check up	Date _____	☐ Not sure	☐ Never

For those 65 years and older: when was the last time you were immunised for -

Influenza	Date_____	☐ Not sure	☐ Never
Pneumococcal pneumonia	Date_____	☐ Not sure	☐ Never
Shingles (Herpes Zoster)	Date_____	☐ Not sure	☐ Never

Is there any other information that you believe we should know that may affect/ or have an influence on the medical treatment / advice you will be provided with? If **Yes**, please provide details below -

_____

_____

_____

_____

Signature: ……..…… **Date: ..... / ..... / .....**

Thank you for your cooperation.
Please return your completed from to reception.

Active Health, PORTLAND. VIC. 3305.
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