

BRIGHTON FAMILY & WOMEN'S CLINIC

NEW PATIENT REGISTRATION FORM – PRINT & BRING INTO CLINIC

Title	Mrs		Ms		Miss		Mr		Dr		
Surname							Date of Birth				
First Name											
Street Address											
Suburb								Postcode			
Postal Address: if different to street address											
Home Phone								Mobile Phone			
Email											
Medicare Number					Number Next To Name			Expiry Date			
Pension Health Care Number								Expiry Date			
Who is Responsible for Payment of Patient Account											
Aboriginal / Torres Strait Islander	Yes		No								
Other Cultural Background	Yes		No		Please identify:						

Next of Kin - Emergency Contact

Name		Relationship	
Home Phone		Mobile Phone	

CONSENT: In keeping with the Privacy Act, we require your written consent with regard to the following.

1. I give consent for Medical information to be obtained by my doctor for the purpose of my medical treatment and passed on to third parties eg specialists for the purpose of further treatment

Yes		No	
-----	--	----	--

2. I give consent for medical reminders, recalls and updates to be sent either my mobile via SMS, email or postal address

Yes		No	
-----	--	----	--

3. I give consent for my contact details to be retained for the purpose of contacting me regarding medical matters or appointments

Yes		No	
-----	--	----	--

4. I give consent for SMS reminders to be sent to me on my mobile prior to my appointment the next day.

Yes		No	
-----	--	----	--

5. I give consent for my personal information to be uploaded to MyHealthRecord via a Shared Health Summary or Event Summary to aid in the consistency and continuation of medical treatment.

Yes		No	
-----	--	----	--

Failure to attend an appointment, or give a **minimum 2 hours' notice** when cancelling, may incur a **cancellation fee**.

Signed: _____ **Date:** _____

How did you hear about our clinic?

Friends / Family		Google		Other - Please Explain:	
------------------	--	--------	--	-------------------------	--

Name: _____

MEDICAL QUESTIONNAIRE:

Our Doctors require this information so that they can become familiar with you and your family's medical history. In accordance with the Privacy Act 1988, Health Records Act 2001 and the Australian Privacy Principals, if you are over 18 years old, your medical information will not be released to family members without your direct consent. Consent must be given at each relevant consultation and recorded in your clinical file. Your doctor will record this consent as requested. Patients between 16 and 18 years should consult their doctor and parents in relation to privacy.

Previous General Practitioner: _____ last seen on _____

Address: _____

Phone: _____

Who completed this form?

Myself		Other	
--------	--	-------	--

If Other, Name & Relationship to patient: _____

Phone: _____

YOUR BACKGROUND:

With whom are you living: _____

Marital Status: _____

Sexuality (optional):

Heterosexual		Homosexual		Bisexual	
--------------	--	------------	--	----------	--

Occupation(s): _____

Are you Retired?

Yes		No	
-----	--	----	--

Do you Smoke?

Yes		No	
-----	--	----	--

If Yes, how many _____ per day; for how many years _____

If you quit smoking, when did this occur?: _____

Do you drink alcohol?

Yes		No	
-----	--	----	--

If yes, how many standard drinks per day?

	Daily		Weekly		Monthly		Rarely		Never
--	-------	--	--------	--	---------	--	--------	--	-------

ALLERGIES:

Do you have any known allergies?

Yes		No	
-----	--	----	--

If Yes, please list the medication or food & type of reaction you experience:

(eg: penicillin - rash) _____

REGARDING YOUR MOTHER & FATHER:

Does your Mother or Father have a history of:	Yes M or F	No M or F	Not sure
High blood pressure			
High Cholesterol			
Heart Disease			
Stroke			
Cancer – please specify what type			
Glaucoma			
Diabetes			
Any other diseases?			

REGARDING YOUR SIBLINGS & OTHER RELATIVES

How many brothers do you have?: _____ alive _____ deceased.

How many sisters do you have?: _____ alive _____ deceased.

Name: _____

Do your relatives have any of the following:	Yes	No	Relative	Not sure
High blood pressure				
High Cholesterol				
Heart Disease				
Stroke				
Cancer – pls specify type & age on onset				
Glaucoma				
Diabetes				
Osteoporosis (Bone weakness)				
Any other diseases?				

WOMEN'S HEALTH (As appropriate)

Do you need to get up during the night to pass urine?:

Yes		No	
-----	--	----	--

If Yes, how often?: _____

Do you lose bladder control when you cough or sneeze?:

Yes		No	
-----	--	----	--

When was your last Pap smear?: Year: _____

Not Sure		No longer applicable	
----------	--	----------------------	--

Was it:

Normal		Abnormal		Not Sure	
--------	--	----------	--	----------	--

When was your last Mammogram (breast x-ray)? _____ year

Not Sure		Never	
----------	--	-------	--

When was your last bone density test?: _____ year

Not Sure		Never	
----------	--	-------	--

In Pregnancy did you have:

High Blood Pressure		Diabetes	
---------------------	--	----------	--

When was your last blood test: date: _____ laboratory: _____

Diabetes and cholesterol screen: date: _____ laboratory: _____

Full physical check up: date: _____

Weight: _____

Height: _____

MEN'S HEALTH (As appropriate)

Do you need to get up during the night to pass urine?:

Yes		No	
-----	--	----	--

If Yes, how often?: _____

Has the strength of the urine stream changed?:

Yes		No	
-----	--	----	--

Has your ability to develop or maintain an erection changed?:

Yes		No	
-----	--	----	--

When was your last blood test: date: _____ laboratory: _____

Diabetes and cholesterol screen: date: _____ laboratory: _____

Full physical check up: date: _____

Weight: _____

Height: _____

SOCIAL HISTORY

Do you have any children?:

Yes		No	
-----	--	----	--

If Yes, _____ Sons _____ Daughters

Are there any medical concerns with any of your children?:

ACTIVITY

Name: _____

What form of weight bearing activity do you do each week eg walking, golf, gardening?:

How many days per week?: _____

Do you ever experience any of the following during or after exercise?:

Breathlessness		Cough		Wheeze		Chest Pain	
----------------	--	-------	--	--------	--	------------	--

IMMUNISATIONS

When was your last: Flu injection _____ Pneumovax _____ Tetanus _____
Have you ever been immunised against: Hepatitis A _____ Year Hepatitis B _____ Year

YOUR PAST MEDICAL HISTORY

Have you had any operations? Please list type & approximate date

Please indicate by ticking which of the following diseases apply to you:

<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Cartoid Blockage	<input type="checkbox"/>	Gout
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Blood Clots/DVT	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	Coronary Artery Disease	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Diverticular Disease	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Dementia/Alzheimer's
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	COPD/Chronic Lung Dis.	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Colon or Rectal Polyps	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Gall Stones	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Irregular Heart Beats	<input type="checkbox"/>	Prostate Disease	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	High Cholesterol Level	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Anaemia
<input type="checkbox"/>	Abnormal Heart Valve	<input type="checkbox"/>	Broken Bones/Amputations	<input type="checkbox"/>	Abnormal Pap Smear
<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Ovarian Problems
<input type="checkbox"/>	Coeliac Disease	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Other (pls explain)

If you have ever had any cancer, please list type & date?:

MEDICATIONS

Please list all medications you take, *including eye drops, herbal, homeopathic or naturopathic remedies, over the counter medications, vitamins, ointments, inhalers or nasal sprays*:

Thank you for taking the time to complete this form. We realise that the form is quite lengthy, but the information provided will help us to get a complete picture of your health issues and assist us in providing the best possible health care for you in the future.