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 18years 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?:

____

____

Name: ___________________________

ACTIVITY

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
____ Year _______
____ Year _______
____ Year _______

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

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

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

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.