davidson family medical practice

CONFIDENTIAL PATIENT DETAILS

Personal Information :

Title : _____ Given Names: _____Surname: _____

Preferred Name (if different from above) _____

Address : _____

Suburb: _____ Postcode : _____

Date of Birth : _____ Male / Female (please circle)

Phone Number : (home)_____(work)_____(mobile) _____

Email address :

_____

Medicare No : _____

Ref No (number next to name): _____ Expiry date: ____ /_____

Do you hold one of the following ?(please tick one):

Pensioner Concession Card ☐ Centrelink HCC ☐ Seniors Health Card ☐ DVA ☐
Colour:_____

Card Number : _____ Expiry date : _____

Do you wish to be recognised as an Aboriginal or Torres Strait Islander ? : Yes / No (please circle)

Next of Kin / Emergency Contact :

Name : _____ Phone Number: _____

Relationship to you : _____

If completing for a child please complete the following details :

Mothers Name : _____ Phone Number : _____

Fathers Name : _____ Phone Number : _____

Signature: _____ **Date** : _____

The personal information you provide during your consultation and subsequent treatment will be collected for the sole purpose of providing high quality healthcare. This practice is committed to protecting your privacy and this information is only disclosed to other member of your treating team where medically necessary. It may however be disclosed to other organisations where required by law.

New Patient Health Information

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ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL

List any current medical problems	
▢ Hypertension (High blood pressure)	▢ Asthma
▢ Heart Disease	▢ High Cholesterol
▢ Diabetes	▢ Breathing problems
▢ Epilepsy	▢ Cancer (list type)
▢ Other (Please list)	
Martial Status : ▢ Single ▢ Married ▢ Divorced ▢ Widowed ▢ De facto ▢ Other	

List any operations you have previously had		
Year	Operation	

List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers currently taken		
Medication Name	Dose	Frequency Taken

Allergies	
Name of medication / product / item	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol?	▢ Yes	▢ No
	How many drinks per week?		
Tobacco	Do you smoke?	▢ Yes	▢ No
	Cigarettes – pkts /day		
	# of years / Or year quit		
Well Women's Checks	Do you have regular pap smears? If so, please list the date of your last pap smear	▢ Yes	Date:

FAMILY HEALTH HISTORY
DO YOU HAVE ANY SIGNIFICANT FAMILY HISTORY? IF SO, PLEASE LIST ILLNESS AND FAMILY MEMBER