Reynolds Rd 7 Day
MEDICAL CENTRE

GP Skin Physio Pod

New Patient Registration

Surname:			First Name:		
Address:					
Home No		Mobile No		Email	
DOB:	Male/ Female		Are you Aboriginal or TSI? Yes ☐ No ☐	Country of Birth	
Medicare No			Ref	Exp	
DVA	Pension/HCC				EXP
Next of Kin			Relationship		
Address					
Phone			Mobile		
Emergency Contact			Phone		

Do you consent to SMS reminders: Yes No

Do you consent to upload to My Health Record: Yes No

Person responsible for accounts:

**** Full Payment is required at the time of consultation by Cash Visa MasterCard****

****Pensioners, Health Care Card Holders and Children under 12 Years old ****

Medical History

Please circle if you have/had any of the following:

Angina/Heart Arthritis Asthma Stroke Blood Pressure (high/Low)

Cancer Diabetes Depression Epilepsy High Cholesterol

Thyroid Gout Kidney Disease Other ________________________________

Past Operations:

Appendix Fractures Gall Bladder Hernia Heart Vasectomy Hysterectomy

Stomach Banding/Sleeve

Other____

Allergies:

Do you have any allergies or are sensitive to any medication, food nuts, drinks dressings?

If yes please provide details: ______________________________

Medications:

Are you currently taking any medication including vitamins, minerals or other health supplements?

If yes please provide details: ______________________________

General:

Do you smoke:	yes	No	if yes how many per day? ____________
Have you ever smoked	Yes	No	if yes what year did you stop? ____________
Alcohol intake	None	Social	Heavy
Has your weight:	Increased	Decreased	Same

When was your last check up: ____________ Last routine Prostate check: ____________

Last routine Breast exam: ____________ Last routine Pap smear: ____________

Are you up to date with vaccinations Yes No Unsure

Family History:

Please circle if you have any family history of the following:

Asthma Diabetes Kidney Disease Heart Disease Hypertension

Cancer – Breast – Prostate - Bowel

Other: ______________________________

Your privacy and medical information:

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. The practice may occasionally be involved in research and quality assurance activities to improve individual and community health and practice management. We wish to assure you that at all time your health information are treated with the utmost confidentiality.

I have read and understood the above information regard my medical information

…………………………………………………………………..

Signature of Patient:

Date: ……………………………………………………………..

How did you hear about us?

Friend/Family Newspaper Facebook Health Engine Google

Other ______________________________