**PATIENT REGISTRATION & INFORMATION FORM**

Please complete and return to reception.

|  |
| --- |
| **PERSONAL CONTACT DETAILS** |
| TITLE (circle): MR MRS MS MISS MASTER DR | GENDER: MALE / FEMALE / OTHER (SPECIFY): |
| MARITAL STATUS (circle): SINGLE MARRIED SEPARATED DEFACTO DIVORCED WIDOWED |
| SURNAME: |
| GIVEN NAME: | MIDDLE NAME: |
| PREFERRED NAME: |
| DOB: | AGE: | ETHNICITY :  |
| COUNTRY OF BIRTH: |
| HOME ADDRESS: |
| SUBURB: | POSTCODE: | STATE: |
| POSTAL ADDRESS (If different to street address): |
| HOME PHONE:  | MOBILE: |
| EMAIL:  |
| OCCUPATION: | E-Health Record (circle): YES / NO |
| To assist with health initiatives - are you an aboriginal or Torres Strait Islander? YES / NO |

|  |
| --- |
| **GOVERNMENT IDENTIFIERS** |
| MEDICARE NUMBER: | PATIENT NUMBER: | EXPIRY: |
| CENTRELINK HCC/PENSION NUMBER: | EXPIRY: |
| DVA NUMBER: | TYPE (GOLD/WHITE/LILAC/ORANGE): | EXPIRY: |
| OSHC/OVHC Company: | Number: | EXPIRY: |

|  |
| --- |
| **EMERGENCY CONTACT** |
| FULL NAME |  |
| RELATIONSHIP |  | GENDER: MALE / FEMALE |
| HOME: | WORK: |
| MOBILE: | EMAIL: |

|  |
| --- |
| **MEDICAL HISTORY** |
|   **Do you have any known allergies?** YES (Please list below) NO

|  |
| --- |
| List allergies: |
| List current medications (include over the counter medications, vitamins and minerals): |

 **Do you have or have you had a history of:**

|  |  |
| --- | --- |
| Asthma |  YES NO COMMENT: |
| Diabetes |  YES NO COMMENT: |
| High Blood Pressure |  YES NO COMMENT: |
| Chronic illness |  YES NO COMMENT: |
| Other |  |
| Operations - Detail | 1. | Date: |
| 2. | Date: |
| 3. | Date: |
| 4. | Date: |

 **Have you been overseas?** YES (Please list countries below) NO

|  |
| --- |
|  |

 **Have you had the following Immunisations?**

|  |  |  |
| --- | --- | --- |
| Tetanus booster | DATE: |  Don’t Know Never |
| Hepatitis A | DATE: |  Don’t Know Never |
| Hepatitis B | DATE: |  Don’t Know Never |
| Influenza | DATE: |  Don’t Know Never |
| Pneumococcal | DATE: |  Don’t Know Never |
| Polio | DATE: |  Don’t Know Never |
| Gardasil 1 | DATE: |  Don’t Know Never |
| Gardasil 2 | DATE: |  Don’t Know Never |
| Gardasil 3 | DATE: |  Don’t Know Never |

 |
| **CHILDREN’S IMMUNISATIONS** |
| If completing this form for a child, are their immunisations up to date? NO YES |
| Current Medications (including over the counter medications, vitamins and minerals): |

|  |
| --- |
| **HEALTH HISTORY** |
| **FAMILY HISTORY - Have any members of your family been diagnosed with or suffered from:**

|  |  |
| --- | --- |
| Asthma |  YES NO RELATIONSHIP TO YOU: |
| Diabetes |  YES NO RELATIONSHIP TO YOU: |
| Heart Disease |  YES NO COMMENT: Age at Diagnosis: |
| Stroke |  YES NO COMMENT: |
| Mental illness |  YES NO COMMENT: |
| Cancers |  YES NO If yes, please specify below. |
| BOWEL: YES NO  | RELATIONSHIP TO YOU: | AGE (If known): |
| BREAST: YES NO  | RELATIONSHIP TO YOU: | AGE (If known): |
| OVARIAN: YES NO  | RELATIONSHIP TO YOU: | AGE (If known): |
| PROSTATE: YES NO  | RELATIONSHIP TO YOU: | AGE (If known): |
| MELANOMA: YES NO  | RELATIONSHIP TO YOU: | AGE (If known): |
| OTHER:  | RELATIONSHIP TO YOU: | AGE (If known): |

**SOCIAL HISTORY**

|  |  |
| --- | --- |
| Tobacco Smoking |  Smoker Ex-smoker Never smoked |
| Number of cigarettes per day: \_\_\_\_\_\_\_\_ Year commenced: \_\_\_\_\_\_\_\_ |
| Last quit attempt: \_\_\_\_\_\_\_\_\_\_  |
| Duration of longest period of abstinence: \_\_\_\_\_\_\_\_\_\_ |
| Alcohol | How often do you have a drink containing alcohol? Never 2-3 times a week Monthly or less 2-4 times a month  4 or more times a week |
| How many **standard drinks** containing alcohol do you have on a typical day? 1 or 2 3 or 4 5 or 6 7 to 9 10 or more |
| How often do you have six or more drink on one occasion? Never Less than monthly Monthly Weekly Daily or almost daily |
| Are you concerned about your drinking? YES NO |
| Recreational Drug Use |  YES NO  |

**BODY MEASUREMENTS**

|  |  |
| --- | --- |
| HEIGHT: | WEIGHT: |
| SEXUALITY: Heterosexual Homosexual Bisexual |
| WAIST MEASUREMENT: | BLOOD PRESSURE: |
| When was the last time your blood pressure was taken? \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ |
| How often do you exercise or engage in physical activity for 30 minutes or more? Daily Times per week Never Other |

 **FEMALES: When did you last have;**

|  |  |  |
| --- | --- | --- |
| Pap Smear | DATE: |  Don’t Know Never |
| Breast Check | DATE: |  Don’t Know Never |
| Mammogram | DATE: |  Don’t Know Never |

 **MALES: When did you last have;**

|  |  |  |
| --- | --- | --- |
| Overall check up | DATE: |  Don’t Know Never |
| Prostate Check | DATE: |  Don’t Know Never |

 **For those 65 years and older: When was the last time you were immunised for;**

|  |  |  |
| --- | --- | --- |
| Influenza | DATE: |  Don’t Know Never |
| Pneumococcal pneumonia | DATE: |  Don’t Know 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: \_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ I confirm there is no other information that I am aware of that would influence the medical treatment/advice to be provided. |
| **REMINDER SYSTEMS** |
| Polaris Medical Centre provides our patients with preventative care and early case detection reminders eg. Immunisations, annual health checks including skin checks and pap smears. |
| Do you offer consent to participate?  |  NO YES  |
| Do you consent to SMS/Email Communication?  |  NO YES  |
| Consent to third Party (e.g.: Specialists etc) |  NO YES  |
| If NO, do you consent to RESULTS being mailed to your home or postal address? NO YES |
| Interpreter Language (If required): |