**PATIENT REGISTRATION & INFORMATION FORM**

Please complete and return to reception.

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| **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 | | | | | | | | |

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| **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: | | |

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| **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): |

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| --- | --- |
| **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): | |