YarraMedical

NEW PATIENT REGISTRATION and INFORMATION UPDATE FORM

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐

Given Name(s): _____ Surname: _____

Preferred Name: _____ Date of Birth: _____ Circle: M F N/A

Unit Number: _____ Street Number: _____ Street Name: _____

Suburb: _____ Postcode: _____

Home Phone No: _____ Work Phone No: _____

Mobile No: _____ Email: _____

Nationality:_____ What is your preferred language?_____

Do you require an Interpreter? Yes ☐ No ☐

Do you identify as: (Circle one) Aboriginal Torres Strait Islander Both Neither

Occupation: _____

Contacts

Emergency: Full Name: _____ Relationship: _____ Contact No:_____

Next of Kin: Full Name: _____ Relationship: _____ Contact No:_____

Communication

Do you consent to SMS reminders? Yes ☐ No ☐

How did you hear about us? Google ☐ Live opposite ☐ Walked past ☐ Friends/family ☐ Other: _____

Medicare and government Issues Cards

Do you have any of the cards below?

Medicare Card ☐ Health Care Card ☐ Pension Card ☐ DVA Card: Gold ☐ White ☐

Previous Screening Tests

Approximate date of colonoscopy: _____ Approximate date of gastroscopy: _____

Approximate date of bowel cancer test: _____ Approximate date of skin cancer check: _____

Approximate date of last pap smear: _____ Approximate date of last mammogram: _____

Weight (kg): _____ Blood Pressure: _____ Waist Circumference: _____

Height (cm): _____ Temperature: _____ BSL (if Indicated): _____

Alcohol and Smoking

Do you drink alcohol? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐

How many days per week do you drink? _____ How many cigarettes per day? _____

How many standard drinks per day? _____

Past drinker ☐ Ex-smoker ☐

Year started: _____ Year stopped: _____ Year started: _____ Year stopped: _____

Office use

Photo ID Sighted (Reception initial): Nurse initial: GP initial:

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Do you have any allergies? Yes ☐ No ☐

Please list all ALLERGIES or adverse reactions

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Medications

Please list all MEDICATIONS that you are currently on

Medication: _____ Strength: _____

Medication: _____ Strength: _____

Medication: _____ Strength: _____

Medical and Surgical History

ACTIVE (Current)	Date Diagnosed	**INACTIVE** (Past)	
Condition: _____	Date (mm/yy):_____	Condition: _____	Date (mm/yy):_____
Condition: _____	Date (mm/yy):_____	Condition: _____	Date (mm/yy):_____
Condition: _____	Date (mm/yy):_____	Condition: _____	Date (mm/yy):_____

Social History

Are you pregnant? Yes ☐ No ☐ Are you breast feeding? Yes ☐ No ☐

What exercise do you do? _____ Are you an elite athlete? Yes ☐ No ☐

Lives with (circle one): Alone Spouse Parents Relative Friend Homeless Other: _____

Family Medical History

Mother – alive? Yes ☐ No ☐ Unsure ☐ Age at death: _____ Cause of death: _____

Father – alive? Yes ☐ No ☐ Unsure ☐ Age at death: _____ Cause of death: _____

Have your family members had any medical conditions? (Circle one): No Unsure Yes, complete below

☐ Diabetes Family Member (Type 1 or type 2): _____

☐ Cancer Family Member (Type of cancer): _____

☐ Heart Disease Family Member _____

☐ High Blood Pressure Family Member _____

☐ Stroke Family Member: _____

☐ Depression Family Member: _____

☐ Other Family Member (Please specify): _____

Privacy Statement:

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment (Enhancing Privacy Protection) Act 2012. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE (for a full copy of clinic privacy statement please ask at reception)

Full Name: _____ Signature: _____ Date: _____

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