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: Aboriginal Torres Strait Islander Both Neither

Occupation: _____

Contacts

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

Next of Kin: Full Name: _____ Relationship: _____ Contact 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? (Please tick)

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

Private Health Insurance

Health Fund: _____ Member number: _____ Reference number: _____

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): _____ Height (cm): _____

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 (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: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Medications

Please list all MEDICATIONS that you are currently on

Medication: _____ Strength: _____

Medication: _____ Strength: _____

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):_____

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): _____

☐ Other Family Member (Please specify): _____

PLEASE CONTINUE ONTO PATIENT CONSENT FOR PRACTICE INFORMATION FORM

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