Carlton Family Medical
88 Rathdowne St Carlton 3053

New Patient Information Form

PLEASE COMPLETE THIS FORM AND RETURN TO RECEPTION
It is essential that your medical records are up to date and accurate

Title		**Prof ☐ Dr ☐ Mr ☐ Mrs☐ Ms ☐ Miss ☐ Other ☐**	
Surname			
First Name & Middle Name			***Preferred Name***
Date of Birth			
Gender Male ☐ Female ☐ Other ☐		**Occupation**	
Ethnicity *(Cultural Background)*			
Street Address			
Suburb and Post Code			
Postal Address *(If different from above)*			
Phone Numbers	**Home**	**Work**	**Mobile**
EMAIL ADDRESS			
For administration purposes what is the best form of contact for you?		**Home ☐ Mobile ☐ Email ☐** **We utilise SMS reminders for appointments. Do you consent to receiving SMS reminders for appointments? Yes☐ No ☐**	
Next of Kin (Name & Phone number) ***(Relationship)***			
Emergency Contact in Australia ***(If different from Next of Kin).*** **Please fill in the name, phone number and relationship of the person we should contact in an emergency**			

To ensure we offer you with all the Medicare funded health initiatives available, please specify whether you are
Aboriginal and / or Torres Strait Islander ☐Yes ☐ No

Are you a full time Tertiary Student Yes ☐ if yes Student Number----------
Are you a visitor to Melbourne? Yes ☐ if yes how long are you staying? ----------

Reminder Systems:
We occasionally send important health care reminders via emails or letter to our patients (e.g. pap smear reminders every two years, reminders for blood glucose checks for women with previous gestational diabetes, repeat bone density testing for people with osteoporosis.) These are very specific and targeted reminders. We do not send newsletters or advertising mail. If you do not want to receive these reminders please advise your doctor during the consultation to ensure this is documented in the file.

Signature----------Date----------

By the way how did you find us?
Website ☐, Recommendation from another person ☐ Previously a patient at MMC ☐
Other_____

Carlton Family Medical

88 Rathdowne St Carlton 3053

NAME:_____ Date of Birth_____ Today's Date:----------

Do you have any **Allergies** or are you sensitive to drugs or dressings? YES / NO
Please list the medication and reaction (eg. rash/breathing problems/swelling etc)

The doctors at Carlton Family Medical will contact you about abnormal results or when you are due for a repeat test (e.g. Pap smear, colonoscopy etc). We phone, email or use SMS for this. Please ensure we have these contact details for you and inform us if they change.
We occasionally notify our patients about illness prevention interventions. (eg. as when flu vaccine becomes available each year.) If you want to be excluded from these very infrequent and targeted contacts please advise your doctor.

Do YOU PERSONALLY have a history of?	**When did you last have?**
Operation (What, when and side)	**Women** Pap smear
Asthma (childhood or active)	Mammogram (over 50 yo.)
High Blood Pressure/High cholesterol/ Gout	**Men** Prostate check (over 50 yo)
Diabetes / Gestational Diabetes (age of onset)	**Men and women** Eye test (Glaucoma/Macular degeneration)
Other (vegan; chronic dis., inherited risk of condition)	**Bowel cancer screen**

Are you up to date with your childhood and school vaccinations? YES / NO

If so, in which State\ Country did you have the Primary Series of vaccines? Victoria / Other :

Year of LAST Influenza vaccination:

Current Medications (including over -the -counter (OTC) medications, vitamins and minerals)

FAMILY HISTORY - Has any member of your immediate & extended family had and the details?

Diabetes Type 1 or Type 2:	Genetic Illness
Heart Attack/ Stroke:	Cancers:
Mental illness:	Premature death:
Blood Clots in Leg or Lung	Other:

Do you smoke cigarettes? YES / NO
Do you drink alcohol? YES / NO

Tobacco: _____ cigs per day or Year that you stopped smoking: _____

Alcohol: How many days do you drink each week? _____ How many standard units on each of these days? _____

Any other drug use? YES/ NO_ : _____

Weight: _____ kgs (or pounds) **Height:** _____cms (or Feet\inches)

PLEASE GIVE THIS FORM TO THE DOCTOR AT THE BEGINNING OF THE CONSULTATION