



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 <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mast <input type="checkbox"/> Other <input type="checkbox"/>		
Surname			
First Name & Middle Name			<i>Preferred Name</i>
Date of Birth			
Birth Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other <input type="checkbox"/>	Occupation		
Pronouns: She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/>	Gender Identity: Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary <input type="checkbox"/> Gender-Diverse <input type="checkbox"/> Transgender <input type="checkbox"/> Different Identity <input type="checkbox"/>		
Medicare Card Number	_____ Ref. No: ____ Expiry: __/____		
Ethnicity (<i>Cultural Background</i>)			
Street Address			
Suburb and Post Code			
Postal Address (<i>If different from above</i>)			
Phone Numbers	Home	Work	Mobile
EMAIL ADDRESS			
For administration purposes what is the best form of contact for you?	Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Email <input type="checkbox"/> We use SMS reminders for appointments. Do you consent to receiving SMS reminders for appointments? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Next of Kin* (Name & Phone number) (<i>Relationship</i>) *Can be overseas phone number			
Emergency Contact in Australia (<i>If different from Next of Kin</i>). 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. cervical screening reminders when due, 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** _____

Whilst you're here, 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)

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 Cervical Screening
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: _____ kg (or pounds) **Height:** _____ cm (or Feet\inches)

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