New patient questionnaire

Title: Dr ☐ Mr ☐ Mrs☐ Ms ☐ Miss☐

Surname: ___________________________

First name(s): ________________________ Preferred Name: _____________________

DOB: ___ / _____ / _______ Occupation: ___________________________

Address: ___________________________ Phone – Home: _________________________

___________________________ Work: ________________________________

Suburb: ___________________________ Mobile: _______________________________

Do you agree to SMS communication?

Yes ☐ No ☐

Postcode : ________________________

Medicare No: ___________________________ Concession Card No: _____________________

No. next to name on card: ____ Exp: ___ / _____ Exp: ___ /___/______

Driver's Licence Number: _____________________ DVA Number_____________________________

Marital Status: ____________________________ Country of Birth____________________________

Emergency Contact: _________________________ Phone: _____________________

Relation to Patient: _________________________

Next of Kin: ____________________________ Phone: ______________________

Relation to Patient: _______________________

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?

☐ No
☐ Yes – Aboriginal or Torres Strait Islander
☐ Cultural background _____________________________________

Are you a former Member of a Defence Force? YES/NO

If YES which Defence Force______________________ Service Number_____________________

PERSONAL HEALTH HISTORY

Allergies: _________________, ___________________, _______________________, ____

Fits, faints or funny turns Yes / No Details: ____

Diabetes Yes / No Details: ____

Heart or blood pressure Yes / No Details: ____

Serious injuries Yes / No Details: ____
____

Arthritis or other joint problems Yes / No Details: ____

Any sort of surgery

Yes / No Details: ____

____

Any other medical issues Yes / No Details: ____

What medication are you on?

Prescription:

_____________________, _____________________, ______________________

Over the counter / Herbal / Others

_____________________, _____________________, ______________________

I, do smoke / did smoke / have never smoked. What age did you start?____ How many cigarettes a day:_____

Do you drink alcohol Yes / No How many standard drinks per week?____

HEALTH PROBLEMS IN YOUR FAMILY THAT MAY AFFECT YOU

___________________________________, _____________________________, ________________
___________________________________, _______________________________, ________________

Current GP Contact Details: __________________________ Contact Number: ______________________

I **agree / do not agree to** Tillyard Drive Medical Practice contacting me via electronic communication such as email Please make sure that email address given must be your own personal email address.

E-mail: ________________________________

I **agree/do not agree** to give permission to Tillyard Drive Medical Practice to access my "MyHealthRecord."

Patient signature: ___________________________________ Date: _____ / _____ / _______