Burton Street Family Practice

New Patient Information Form

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

This form complies with the RACGP *Standards for general practices*. This means your personal health information remains private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Section A: Personal details

Title: (please circle) Mr / Mrs / Ms / Miss / Master	Surname:	Given Names:
Date of Birth: / /	Gender:	Marital Status: (please circle) Single / Married / Defacto / Separated / Divorced / Widowed
Occupation:		
Home Address: Suburb:		Postcode:
Postal Address: Suburb:		Postcode:
Home No:	Work No:	
Mobile No:	Email:	
Medicare Card No:	Reference No:	Expiry Date: / /
Concession Type: (please circle applicable) Pension / Health Care Card / Commonwealth Seniors Health Card / Veterans Affairs Card – Type: Gold / White		
Concession Card No:	Expiry Date: / /	White card specific Conditions:
Private Health Cover: ☐ Yes ☐ No	Card No:	
Fund Name:	Expiry Date:	
Next of Kin:	Relationship:	
Home No:	Work No:	Mobile No:
Emergency Contact:	Relationship:	
Home No:	Work No:	Mobile No:

Section B: Cultural background

Studies show that our cultural background may place us at different risks for certain diseases. By knowing more about your racial and ethnic background, we can get a better idea of health risks you may have and better meet your health needs.

Are you of Aboriginal or Torres Strait Islander origin?		
☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander		
If not, what is your cultural background: (e.g. Australian, British, Mediterranean, Asian, African)		
What is your country of birth?		
Is English your first language? ☐ Yes ☐ No	If not, do you require an interpreter? ☐ Yes ☐ No	Please specify language:

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Section C: Health information

– Additional space provided on back page if required –

Your health history:

Do you have or have you had a history of the following? (please provide details)	
☐ Asthma	☐ Cancer
☐ Chronic illness (please specify)	☐ Heart Disease
☐ Diabetes	☐ High cholesterol
☐ High blood pressure	☐ Mental illness e.g. depression/anxiety/bipolar
☐ Kidney disease	☐ Other (please specify)
☐ Stroke	

Do you have a current Chronic Disease Management Plan in place?	☐ Yes ☐ No
If so, when is this plan due for review?	Date: / /

If you are over 75, have you had a Health Assessment in the last 12 months?	☐ Yes ☐ No

Family health history:

Have any family members had any of the above conditions?	☐ Yes ☐ No
Details: (include the condition and family member)	

Surgical history:

Have you had any surgical procedures?	☐ Yes ☐ No
Details: (include date if known)	

Allergies and adverse reactions:

Do you have any allergies or are you sensitive to drugs or dressings?	☐ Yes ☐ No
Details: (include details of reactions)	

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Adult immunisations:

Tetanus booster	Date:	☐ No	☐ Don't know
Hepatitis B	Date:	☐ No	☐ Don't know
Hepatitis A	Date:	☐ No	☐ Don't know
Influenza	Date:	☐ No	☐ Don't know
Pneumococcal	Date:	☐ No	☐ Don't know
Polio	Date:	☐ No	☐ Don't know

Child immunisations:

If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

Current medications: (include over the counter medications, vitamins and minerals)

Name	Strength	Dose

Social history:

Smoking	☐ No	☐ Yes	Cigarettes per day:
		☐ Ceased	Date ceased:
Alcohol	☐ No	☐ Yes	Standard drinks per day:
Recreational drug use	☐ No	☐ Yes	Type and frequency:

Females:

When did you last have?

Pap smear (cervical screening test)	Date:	☐ Not sure	☐ Never
Mammogram	Date:	☐ Not sure	☐ Never

Reminder Systems:

Our practice is committed to management and preventative care of medical conditions. We use a reminder system to offer our patients preventative health services appropriate to their care such as immunisations, pap tests and annual health reviews. The practice sends reminders by post and telephone or via a third party (e.g. HotDoc, Health engine) via post and SMS.

What is your preferred method of contact:

☐ Mail ☐ Phone ☐ SMS ☐ Email

Transfer of medical records:

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

How did you hear about us? _____

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Additional space:

Your medical history:

Your surgical history:

Family health history:

Current medications: (include over the counter medications, vitamins and minerals)

Name	Strength	Dose