New Patient Demographics

Contact Information	
Gender :	
Title :	
Surname:	
First Name:	
DOB:	
Street Address	
Postal Address (if different to above)	
Home Phone	
Work Phone	
Mobile Phone	
Email	

Emergency Contact Details	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Next of Kin	
Name:	Relationship to you:
Home Phone	
Mobile Phone:	

Medicare/Concessions		
Medicare Number:	REF	Expiry / /
DVA Number:	☐ Gold ☐ White	
Concession (Pension/Health Care) Card Number:		Expiry: / /

Cultural Identity

To assist with health Initiatives – are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes Torres Islander ☐ Yes – Aboriginal and Torres Strait Islander

Country Of Ethnicity_____

Do you wish to be identified as any other cultural Background _____

Your Health Infomation

Allergy Information – Do you have any allergies or are you sensitive to any drugs or dressings?

☐ No

☐ Yes provide details: _____

Medical History – Do you have or have you had a history of the following

☐ Surgery – provide details

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Chronic illness

☐ Other – Provide details

Lifestyle Risk Factor Information

Smoking

☐ No

☐ Ceased – date ___/___/____

☐ Yes – how many ___day /___week

Alcohol

☐ No

☐ Yes how many ____day /___week / ____month

Recreational Drug Use

☐ No

☐ Yes – type_____ frequency _____

Current Medications – Please list all current medications, including complementary and over the counter medicines (e.g. homeopathic medicines such as vitamins and minerals.)

Family Health History Information

Have any member of your family have

☐ **Heart Disease**

☐ **Asthma**

☐ **Diabetes**

☐ **Hypertension (hight blood pressure)**

☐ **Mental Illness**

☐ **Cancer - type**

☐ **Other significant – provide details**