Better Health
FAMILY CLINIC

New Patient Medical History

Patient Details

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname: ______________________ First Name: ______________________

Date of Birth: _______/_______/__________ Sex: Male / Female / Other: ______________

Street Address: ____

Suburb: ______________________ Postcode: ______________________

Phone: H ________________ W ________________ M ________________

Email: ____

Concession Cards

Medicare Card Number ______________________ Ref ______ Expiry:__________

Pension/HCC Number ______________________ Expiry:__________

DVA Card Number ______________________ Expiry:__________

Emergency Contact or Next of Kin

Name: ________________ Relationship: ______________ Phone: ______________

Past Medical Records/History

Would you like to transfer your past medical records/history to BHFC?0

☐ No ☐ Yes, from: ____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds, do you identify as someone from a culturally and/or linguistic diverse background?

☐ No ☐ Yes ____

Are you an Aboriginal or Torres Strait Islander?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

______________________ ______________________

______________________ ______________________

______________________ ______________________

PLEASE TURN OVER

Reminder Systems
Our practice provides our patients with preventive care and early case detection reminders (e.g. immunisations, annual health checks, skin checks and pap smears)

Do you agree to having relevant health reminders sent to you: ☐ Yes ☐ No
If yes, do you agree to having these reminders sent to you via Email or SMS ☐ Yes ☐ No

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

☐ No ☐ Yes ____

Do you Smoke?

☐ No ☐ Yes _____ Per Day

Do you Drink Alcohol?

☐ No ☐ Yes _____ Per Day

Do you or have you had a history of the following? (please elaborate)

☐ Operations ____________________________

☐ Asthma ______________________________

☐ Diabetes _____________________________

☐ Hypertension __________________________

☐ Chronic Illness _________________________

☐ Other ________________________________

Immunisations
Have you had the following immunisations? (List date where appropriate)

Tetanus Booster	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis B	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis A	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Influenza	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Pneumococcal	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Polio	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know

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

Is there anything else you would like your doctor to know?

____

____

Patient Declaration

I have read and understand he information above. I understand that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of health care given to me.

Signed: ____ Date: _____/_____/_____