We are committed to providing our patients with the best care. To do this it is essential that your contact details are kept up to date and accurate.

Title	**Mr Mrs Ms Miss**			
Surname				
First Name				
Date of Birth		**Do you identify with any specific cultural background?** Aboriginal ☐ TSI ☐ No ☐ Other ……		
Street Address				
Suburb and Post Code				
Phone Numbers:	**Landline:**	**Mobile**:		
	Do you consent for us to sending SMS reminders to this mobile? Yes / No			
Email :				
Medicare Number & Ref		**Expiry**		
DVA Gold or White		**If white card – what conditions:**		
Pension Number		**Expiry**		
Health Care Card		**Expiry**		
Private Health Cover				
Next of Kin	(Name and Telephone number) (Relationship)			
Emergency Contact (Different person)	(Name and Telephone number if NOK unavailable) (Relationship)			

THE PRIVACY ACT (2001)

We are committed to protecting your privacy. We are now asking for your express consent for the use and disclosure of your personal health information in the course of your health care.
I consent to use of my personal health information by Doctors of Tewantin and other health providers involved in my medical treatment and health care. I consent to the disclosure to other providers directly or indirectly involved with my personal health care and medical treatment.

Full Name: …… Signed: ……
On behalf of: …… Date: .....

HOW did you hear about our Practice? .....

WHY did you choose our Practice? ……

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

☐ Yes (please list below) ☐No

_____

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

_____
_____
_____
_____
_____
_____

Your health history - do you have, or have you had, a history of?

☐ Operations _____

☐ Asthma _____

☐ Diabetes _____

☐ Hypertension _____

☐ Chronic illness _____

☐ Other _____

Family history - have any members of your family had:

☐ Diabetes _____

☐ Asthma _____

☐ Heart Disease _____

☐ Mental illness _____

☐ Cancer _____

Social history:

☐ Tobacco: _____ day / week or Ceased Smoking - date _____

☐ Alcohol: _____ day / week / month (circle the one applicable)

☐ Drug use: _____ (type and frequency)

For those 65 years and older: when was the last time you were immunised?

Influenza	Date_____	☐ not sure	☐ never
Pneumococcal pneumonia	Date_____	☐ not sure	☐ never

Females: When did you last have?

Pap smear	Date_____	☐ not sure	☐ never
Breast Check	Date_____	☐ not sure	☐ never

Males: When did you last have?

An overall check up	Date _____	☐ not sure	☐ never

Sun protection: How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

Immunisations - have you had the following immunisations?

Tetanus booster	date_____	☐ Don't Know	☐ Haven't had one
Hepatitis B	date_____	☐ Don't Know	☐ Haven't had one
Hepatitis A	date_____	☐ Don't Know	☐ Haven't had one
Influenza	date_____	☐ Don't Know	☐ Haven't had one
Pneumococcal	date_____	☐ Don't Know	☐ Haven't had one
Polio	date_____	☐ Don't Know	☐ Haven't had one

Children's immunisations - if completing this form for a child are their immunisations up to date?

☐ Yes ☐ No

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

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

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 wish to have any relevant health reminders sent to you?

☐ Yes – mail ☐ Yes – SMS to this phone number ……☐ No

If we need to contact you what is your preferred method of contact:

☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email

Do you have any health concerns that you would like to receive more information on?

_____

PRACTICE NURSE:

HT …….. WT ……. BP ……. EYES …….. BGT ……. H/A BOOKED