**NORTH COBURG MEDICAL CENTRE PATIENT REGISTRATION FORM**

**HOW DID YOU HEAR ABOUT US** **🞎** INTERNET **🞎** FRIEND/FAMILY **🞎** HEALTH ENGINE **🞎** PHARMACY

**🞎**NEWSPAPER **🞎**OTHER………………………………………………….

***Please ensure that you answer all questions and hand back to reception once completed. (PLEASE PRINT)***

*Thank you for taking the time to complete this form.*

|  |  |  |
| --- | --- | --- |
| **TITLE:** | | 🞎 MR 🞎 MRS 🞎 MS 🞎 MISS 🞎 MSTR 🞎 OTHER: |
| **SURNAME:** | |  |
| **FIRST NAME:** | |  |
| **PREFERRED NAME:** | | **Date of Birth:** \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ |
| **ADDRESS:** | |  |
| **POSTAL ADDRESS** | | (If different to street address): |
| **MOBILE PHONE: WORK PHONE: HOME PHONE:** | | |
| **EMAIL ADDRESS:** |  | |

|  |  |  |
| --- | --- | --- |
| **MEDICARE NUMBER:** | Ref: | Expiry Date: |
| **DVA NUMBER:** |  | Expiry Date: |
| **PENSION / HCC NUMBER:** |  | Expiry Date: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EMERGENCY CONTACT** |  | **NEXT OF KIN** *(If different to Emergency Contact)* | | |
| FULL NAME: |  | FULL NAME: |  |  |
| RELATIONSHIP TO PATIENT: |  | RELATIONSHIP TO PATIENT: | |  |
| ADDRESS: |  | ADDRESS: | |  |
| CONTACT NUMBERS: | HOME:  MOB: | CONTACT NUMBERS: | | HOME:  MOB: |
| *Please note!*  *In an emergency your contact nominated person may be given information relating to your health* | |  | | |

|  |  |  |
| --- | --- | --- |
| **Are you currently taking any medication?** **🞎** Yes, please list **🞎** No  *Please include ALL tablets, inhalers, patches, gels or injections as well as any “natural” remedies or supplements.* | | |
|  | Dose per day: | Frequency: |
|  | Dose per day: | Frequency: |
|  | Dose per day: | Frequency: |
|  | Dose per day: | Frequency: |

**Do you have any allergies or are you sensitive to any drugs or dressings? 🞎** Yes (please list and describe reaction below) **🞎** No

......................................................................................................................................................................................................

**Do you identify as someone from a culturally and/or linguistic diverse background, and if so do you require a translator?**

Yes - Please elaborate…………………………………………………………………………………………

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

**🞎** Yes - Aboriginal **🞎** Yes - Torres Strait Islander **🞎** Yes - Aboriginal & Torres Strait Islander **🞎** No

Are you an Interstate or Overseas visitor to Melbourne? **🞎** Yes **🞎**No

**Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you, or have you had a history of:** | |  | | |
| **🞎** Operations: Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_**  Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | |  |
| **🞎** Asthma | **🞎** Heart Disease | | **🞎** Mental Illness (please elaborate): | |
| **🞎** Thyroid Disease | **🞎** Stroke | | **🞎** Cancer (type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **🞎** Diabetes | **🞎** Blood clot/s | | **🞎** Other (please elaborate):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **🞎** Arthritis | **🞎** High Blood Pressure | |

|  |
| --- |
| **Do you have a family history of any of the above?**  **🞎** Yes, please elaborate **🞎** No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **FEMALES:** | | | |
| When did you have your last: |  |  |  |
| Pap Smear: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Breast Check: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Mammogram: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Bowel Screening: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Skin Check: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Immunisation, what was it?: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Are you currently pregnant? | **🞎** Yes  **🞎** No |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **MALES:** | | | |
| When did you have your last: |  |  |  |
| Prostate Check: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Testis Check: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Health Check: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Bowel Screening: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Skin Check: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Immunisation, what was it?: | Date: **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |  |  |
| --- | --- | --- | --- |
| **FOR THOSE 65 AND OLDER:** | | | |
| When were you last immunized for: |  |  |  |
| Influenza: | Date: \_**\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |
| Pneumococcal pneumonia: | Date: **\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_** | **🞎** Not Sure | **🞎** Never |

|  |  |  |  |
| --- | --- | --- | --- |
| **SOCIAL HISTORY:** |  |  |  |
| Tobacco | **🞎 Yes**  Year started:\_\_\_\_\_\_\_  Frequency: **\_\_\_\_\_** per day | **🞎 No** | **🞎 Ex-Smoker**  Year quit: \_\_\_\_\_\_\_ |
| Alcohol | **🞎 Yes**  **🞎** Occasional **🞎** Moderate **🞎** Heavy | **🞎 No** |  |
| Marriage Status | **🞎** Single  **🞎** Married  **🞎** Separated  **🞎** Divorced  **🞎** Widowed  **🞎** Defacto | | |

Is there any other information that you believe we should know about that may affect or have an influence on your medical treatment?

**🞎 No 🞎 Yes,** if **yes**, please provide details below -

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT PRIVACY:** To provide a high standard of medical care we need to collect personal information from our patients. Thisinformation is usually collected from the patient but also from family members and other health care providers. At times some of this information needs to be shared with doctors auditing our medical records as part of the RACGP accreditation process and other health care providers or we may be legally bound to disclose personal information. All persons accessing your health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor.

***Practice Information Brochure*** *If you are a new patient please ask at reception for a copy of our Practice Information Brochure.*

***Personally Controlled eHealth Record*** *If you would more information or assistance in creating your* ***Personally Controlled eHealth Record*** *please make an appointment with the Practice Manager*.

**Signature:** ……………………………………........................…. **Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_**