Patient Registration Form

GAP ROAD Medical Centre

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. Could you please assist us by completing the following:

Title	**Mr**	**Mrs**	**Ms**	**Mast**	**Miss**
First name					
Surname					
Date of Birth					
Street Address					
Suburb and Post Code					
Home Phone			**Mobile Phone**		
Country Of Birth					
Medicare Number		**Ref No**	**Expiry Date**		
DVA Gold / White			**Expiry Date**		
Pension Number			**Expiry Date**		
Health Care Card Number			**Expiry Date**		
Occupation					
Next of Kin or Emergency Contact	Name		Phone		Relationship to You

Do you identify as Aboriginal or Torres Strait Islander?

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

Do you identify as any other Cultural Background? ______________________

____

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

☐ Yes (List) ☐ No

____

Your health history - do you have a history of?

☐ Operations ☐ Chronic Illness ☐ Other

☐ Asthma ☐ Hypertension ☐ Diabetes

____

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** ☐ **No**

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

Immunisations - have you had the following immunisations?

	Yes	Unsure
Tetanus booster	☐	☐
Hepatitis B	☐	☐
Hepatitis A	☐	☐
Influenza	☐	☐
Pneumococcal	☐	☐
Polio	☐	☐

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

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Family history - have any members of your family had:

☐ Diabetes
☐ Asthma
☐ Heart Disease
☐ Mental Illness
☐ Cancer

Social history

☐ Cigarettes: ……….. day / week **OR** Ceased Smoking: date …………………
☐ Alcohol: ……………………….. day / week / month (circle the one applicable)
☐ Drug use: ………………………………………. (type and frequency)

Height: ………… cms **Weight:** ……… kgs

Blood Pressure: when was the last time your blood pressure was taken? …………………..

Females:

When did you last have?:

Pap smear: Year:……………. ☐ not sure ☐ never
Breast Check: Year…………….. ☐ not sure ☐ never

Males:

When did you last have?:

An overall check up Year…………….. ☐ not sure ☐ never