WALCHA GENERAL PRACTICE CLINIC

104E Fitzroy Street, WALCHA NSW 2354

Patient Information Form

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	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	
Surname		
First Name		
Date of Birth		
Birth Sex	**Gender Identity**	
Street Address		
Suburb and Post Code		
Home Phone		
Work Phone		
Mobile Phone		
Email		
Medicare Number & Ref	#:	Expiry:
☐ **DVA Gold** ☐ **DVA White** (Please tick which)	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Private Health Cover	Name: #:	
Next of Kin (Name and Telephone number)		
Emergency Contact (Name and Telephone number of the person we can contact if needed)		
Employer Name		
Employer Address		
Employer telephone no.		

Patient Information Form... Cont'd

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 – by Mail	☐ No
If we need to contact you what is your preferred method of contact:	
☐ Home Phone ☐ Mobile	☐ Mail
Are there any health concerns that you would like to receive information on?	

Patient Background

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. Please elaborate:
To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?
☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait Islander ☐ Yes ☐ No - Consent to register for CTG

Patient Information Form... Cont'd

Your Health History

Do you have or have you had a history of the following? (please elaborate)
☐ Operations
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other
Do you have any allergies or are you sensitive to drugs or dressings?
☐ No ☐ Yes. Please elaborate:

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

Current Medications

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

Patient Information Form... Cont'd

Family History

Have any members of your family had: (please elaborate)
☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Mental Illness
☐ Cancer

Social History

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ No. ☐ Yes. Number ____ day / ____ week **or** ☐ Ceased smoking
Alcohol	☐ No. ☐ Yes. Number ____ day / ____ week / ____ month
Drug Use	☐ No. ☐ Yes. Type _____ / Frequency _____

Measurements

Height	_____ cm
Weight	_____ kg

Blood Pressure

When was the last time your blood pressure was taken?

Sun Protection

How often do you use the following to protect yourself from the sun when outdoors?					
Protective clothing	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never
Sunscreen creams	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never

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?