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	
Middle Name	

Date of Birth	
Birth Sex	
Gender Identity	

Street Address	
Suburb and Post Code	
Home Phone	
Work Phone	
Mobile Phone	
Email	

Medicare Details:	#:	
	Reference:	
	Expiry:	
☐ **DVA Gold** ☐ **DVA White**	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Commonwealth Seniors	#:	Expiry:
Private Health Cover	Fund:	
	Member Number:	

Next of Kin + Relationship	Name:
	Relationship:
	Contact number:
Emergency Contact + Relationship	Name:
	Relationship:
	Contact number:

Employer Name	
Employer Address	
Employer telephone no.	

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MyMedicare

We are a MyMedicare registered practice.

Are you registered with My Medicare?

☐ No – If you would like to register, please see reception who can provide you with a form.

☐ Yes – You will need to update your registration using your MyGov app or portal to **Walcha General Practice Clinic**, ensuring you change the doctors name.

Previous Records

Would you like to have your records transferred from your previous medical practice to us?

☐ No

☐ Yes – Please provide details of your previous practice including your doctors name

Please note: Reception will arrange for a consent form to be prepared, which will need to be signed by you before it can be sent to your previous practice.

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? Eg: Born outside of Australia

☐ No

☐ Yes. Please elaborate:

Do you speak a language other than English?

☐ No

☐ Yes – Please specify _____

Do you identify as Aboriginal or Torres Strait Islander?

☐ No

☐ Prefer not to say

☐ Yes - Aboriginal

☐ Yes - Torres Strait Islander

☐ Yes – Both Aboriginal & Torres Strait Islander

☐ Yes ☐ No - Consent to register for CTG

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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
Shingles	☐ 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:

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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/Vape	☐ No. ☐ Yes. Number ____ day / ____ week **or** ☐ Ceased smoking – Date _____
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

Overall Checkup	Date:	☐ Not sure	☐ Never