classic way
• FAMILY PRACTICE •

P: 07 5568 0600 | F: 07 5568 0800
www.classicwayfamilypractice.com.au
2/6 Classic Way, Burleigh Waters QLD 4220
Mon - Fri: 7.30am - 5pm | Sat: 8.30am - 12.30pm

NEW PATIENT INFORMATION FORM

We are committed to providing the best possible patient care. Please assist us in maintaining up-to-date records by completing this form.

SURNAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____

MOBILE: _____

YOUR OCCUPATION: _____

MARITAL STATUS: _____

MEDICARE NO: _____ REF:_____

EXPIRY DATE: _____

DVA GOLD / WHITE: _____ EXP:_____

PENSION NUMBER: _____ EXP:_____

HEALTH CARE CARD NUMBER: _____ EXP:_____

PRIVATE HEALTH COVER: _____

DO YOU GIVE CONSENT FOR REMINDERS TO BE SENT TO YOU FROM THIS MEDICAL PRACTICE? YES / NO

NEXT OF KIN

NAME: _____

PHONE: _____ RELATIONSHIP TO YOU: _____

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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?

YES / NO (PLEASE ELABORATE) _____

_____

DO YOU IDENTIFY AS AN ABORIGINAL OR TORRES STRAIT ISLANDER? PLEASE SPECIFY:

_____

YOUR HEALTH HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD A HISTORY OF: (PLEASE SPECIFY):

OPERATIONS? _____

DIABETES? _____

HYPERTENSION? _____

ASTHMA? _____

OTHER? _____

DO YOU HAVE ANY ALLERGIES TO DRUGS OR DRESSINGS? YES / NO

PLEASE LIST: _____

IMMUNISATIONS

HAVE YOU HAD ANY OF THE FOLLOWING IMMUNISATIONS?

TETANUS BOOSTER	DATE:_____	OR DON'T KNOW / HAVEN'T HAD ONE
HEPATITIS A	DATE:_____	OR DON'T KNOW / HAVEN'T HAD ONE
HEPATITIS B	DATE:_____	OR DON'T KNOW / HAVEN'T HAD ONE
INFLUENZA	DATE:_____	OR DON'T KNOW / HAVEN'T HAD ONE
PNEUMOCOCCAL	DATE:_____	OR DON'T KNOW / HAVEN'T HAD ONE
POLIO	DATE:_____	OR DON'T KNOW / HAVEN'T HAD ONE

CHILDREN'S IMMUNISATIONS: (IS THE FORM BEING FILLED OUT FOR A CHILD)

IS THE CHILD UP TO DATE WITH IMMUNISATIONS? YES / NO

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CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER, VITAMINS AND MINERALS)

_____

_____

_____

FAMILY HISTORY: PLEASE SPECIFY IF ANY FAMILY MEMBERS HAVE HAD THE FOLLOWING?

(EG: MOTHER /FATHER/BROTHER ETC)

DIABETES? _____

ASTHMA? _____

HEART DISEASE? _____

MENTAL ILLNESS? _____

CANCER? _____

SOCIAL HISTORY: PLEASE INCLUDE AN ESTIMATE CONSUMPTION FIGURE)

TOBACCO: _____ DAY / WEEK OR CEASED SMOKING DATE: _____

ALCOHOL: HOW OFTEN DO YOU DRINK? PLEASE CIRCLE: DAILY / WEEKLY / MONTHLY

HOW MANY DRINKS WOULD YOU HAVE AT A TIME? _____

DUG USE: (TYPE AND FREQUENCY) _____

PERSONAL INFORMATION

HEIGHT: _____ CMS WEIGHT:_____KGS

BLOOD PRESSURE: INCLUDING DATE OF LAST READING: _____

FEMALES: WHEN DID YOU HAVE YOUR LAST:

PAP SMEAR: DATE: _____ RESULT: NORMAL / ABNORMAL

BREAST CHECK: DATE: _____ RESULT: NORMAL / ABNORMAL

MALES: WHEN DID YOU HAVE YOUR LAST:

PROSTATE CHECK: DATE: _____

OVERALL CHECK-UP: DATE: _____

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PROTECTIVE CLOTHING

DO YOU WEAR SUN PROTECTIVE CLOTHING? YES / NO / SOMETIMES

SUNSCREEN: YES / NO / SOMETIMES

THANK YOU.

PLEASE RETURN CLIPBOARD AND PEN TO RECEPTION AND GIVE THIS FORM TO YOUR DOCTOR AT YOUR APPOINTMENT.