Weston Creek Family Medicine
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.

Please tick Dr □ Mr □ Mrs □ Ms □ Miss □	**Surname**	**Given Names:** **Preferred Name:**
Date of birth ………. / ………. /……….	**Sex:** **Male □** **Female □** **Transgender □**	

Marital status: Single □ Married □ De Facto □ Separated □ Divorced □ Widowed □

ADDRESS:………………………………………………………………… ……………………………………………………………………… ………………………………………………………………………	**Home Ph:** …………………………………………………………… **Mobile Ph:** …………………………………………………………… **Work Ph:** …………………………………………………………… **Email:**……………………………………………………………………

Medicare Number & Ref : ……………………………………………………………… **#:** ……………… **Expiry:** ……………………….

***Children under 18yrs, provide Medicare Care Holders Name & Date of Birth**

***Name:** ………………………………………………………………………………………**Date of Birth:**……………………………………….

DVA Number: ……………………………………………………………………………………… **DVA Gold** ☐ **DVA White** ☐

DVA Disability Number:………………………………………………………………………………………………………

Pension Card or Health Care Card Number: ……………………………………………………………………………

Next of Kin

Name:……………………………………………………………………………… **Phone:**…………………………………………………

Emergency Contact

Name:……………………………………………………………………………… **Phone:**…………………………………………………

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:

□ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander □ Australian

□ Other Nationality/cultural background …………………………………………………… □ You choose not to identify

Appointment & Recall Reminder Systems

Our practice provides patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears and txt reminders for patient appointments.

Do you wish to have any relevant reminders sent to you?

□ Yes – by mail □ Yes – by email □ by SMS □ No

If we need to contact, you what is your preferred method of contact

□ Home phone □ Mobile □ Email □ Mail

Signature ……………………………………………………………………………………………… **Date** ……. / ……. / …………

Patient ☐ **Guardian** ☐ **POA** ☐

Weston Creek Family Medicine
Patient Information Form - Your Medical History

WESTON CREEK FAMILY MEDICINE
We wish you a healthy life

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: ……………………………………………………………………………………

Measurements: Height ………………… cm Weight ……………… kg

Current Medications

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

………

………

………

Family History Have any members of your family had:

- ☐ 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 ______________________

WESTON CREEK FAMILY MEDICINE
We wish you a healthy life

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 Immunisation
If completing this form for a child is their immunisations up to date?
□ Yes □ No

For those 65 years and older:
When was the last time you were immunised?

Influenza	□ Yes	Date:	□ Not sure	□ Never
Pneumococcal	□ Yes	Date:	□ Not sure	□ Never
Pneumonia	□ Yes	Date:	□ Not sure	□ Never

Females
When did you last have?

Pap Smear	□ Yes	Date:	□ Not sure	□ Never
Breast Screen	□ Yes	Date:	□ Not sure	□ Never

Males
When did you last have?

Overall check-up	□ Yes	Date:	□ Not sure	□ Never