LOWNDES Street Clinic

9 Lowndes Street, Kennington 3550
Ph: 03 5443 5117 Fax: 03 5443 5200
admin@lowndesstreetclinic.com

# New 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 | |
| **Full Name :** | **Date of Birth :** |
| **Full Address :** | **Home Phone :** |
| **Mobile Phone :** | **Email :** |

| | | |
|---|---|---|
| **Medicare Number & Ref** | #: | |
| ☐ **DVA Gold** ☐ **DVA White** (Please tick which) | #: | Expiry: |
| **Pension Number** | #: | Expiry: |
| **Health Care Card Number** | #: | Expiry: |
| **Private Health Cover** | Name:<br>#: | Expiry: |
| **Next of Kin** (Name and Telephone number) | | |
| **Emergency Contact** (Name and Telephone number of the person we can contact if needed) | | |

**How did You hear about the practice?**

☐Yellow pages ☐Google ☐ Other Internet search ☐Business card
☐Street Sign ☐Word of Mouth ☐Chemist
☐Other, please specify: _____

**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.

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

☐ Home Phone ☐ Mobile ☐ Mail

**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

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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 |
| ☐ Other medical conditions : |

| **Do you have any allergies or are you sensitive to drugs or dressings?** | | |
|---|---|---|
| ☐ No ☐ Yes. Please Advise each Drug and the reaction : | | |
| 1- | 2- | 3- |
| 4- | 5- | 6- |

### 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:** |
|---|
| |

## Family History

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

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

### Females

| **When did you last have?** | | | |
|---|---|---|---|
| Pap Smear | Date: | ☐ Not sure | ☐ Never |
| Breast Check | Date: | ☐ Not sure | ☐ Never |