

 **Tatton Medical Centre**

 3 Stirling Boulevard Tatton

Title \_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_

Birth Gender: Male □ Female □
Gender Identity: Male □ Female □ Non-Binary □ Transgender □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Pronouns: She/Her/Hers □ He/Him/His □ They/Them/Theirs □

**Do you identify as Aboriginal or Torres Strait Islander?**
□ Yes, Aboriginal □ Yes, Aboriginal & Torres Strait Islander □ Yes, Torres Strait Islander
□ Neither □ I am part of the Closing the Gap (CTG) Program

Country of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred method of contact for results, recall reminders etc.**□ Home □ Work □ Mobile □ I consent to SMS reminders for upcoming appointments

**Details relating to Billing:**

Medicare Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Line No \_\_\_\_\_\_\_\_ Expiry \_\_\_\_/\_\_\_\_\_\_

Veteran Affairs Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry \_\_\_\_/\_\_\_\_/\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Pension Concession Card □ | Health Care Card □ |  |

Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR □ Retired

**Other Contact Information:**

Next of Kin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact *(if different from next of kin)***

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your preferred language if not English? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require an interpreter □ Yes □ No

**Allergies:**

Do you have any allergies or are you sensitive to any drugs or dressings? □ Yes □ Nil Known
If yes what are you allergic to? Reaction/Symptoms:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Severity:** □ Mild □ Moderate □ Severe

 Blood Group \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking Status:**

□ Non Smoker □Smoker □ Ex-Smoker

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Per Day\_\_\_\_\_\_\_\_  |  Year Started \_\_\_\_\_\_\_\_\_\_\_\_\_  |  Year Stopped\_\_\_\_\_\_\_\_\_\_\_ |

**Alcohol – Days a week you drink alcohol**

□ Never (non-drinker / under 18 years of age)

□ 1 – 2 days/week □ 3 – 4 days/week □ 5 – 6 days/week □ Everyday

On a day you drink alcohol, how many standard drinks do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you a carer or does someone care for you?** □ No □ Yes – please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **Is there any significant family history:**

Maternal Side of Family *(mother’s side)* Paternal Side of Family *(father’s side)*

|  |  |
| --- | --- |
| □ Diabetes | □ Hypertension |
| □ Heart Disease | □ Colon Cancer |
| □ Stroke | □ Depression |
|  |  |

|  |  |
| --- | --- |
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**Any medical history we should know about?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information Handling Procedures: Patient Consent**

This practice is bound by the National Privacy Principals. These principals set the standard by which we handle personal information collected from patients. As part of our commitment to you to provide quality healthcare, personal information is sought from you in order to provide a proper assessment, diagnosis and treatment of a condition for which you are attending our practice. Your personal information may be disclosed to others involved in your healthcare, including other treating doctors and specialists. Your medical file will be handled with the upmost respect for your privacy.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_