

This form is to be completed by new patients

Where did you hear about us? (please circle)					
Bunyip	Herald	Friend/Family	Other Practice	Hospital	Other: _____

PATIENT DETAILS					
Title		Surname			
Given Names			Preferred Name		
Date of Birth	/	/	Gender	Male	Female
Do you identify as being of Aboriginal and/or Torres Strait Islander origin?				Are you a Refugee?	
No Yes, Aboriginal Yes, Torres Strait Islander Yes, Both				Yes / No	
Residential Address					
Suburb				State	Postcode
Postal Address					
Suburb				State	Postcode
Home Phone			Mobile		
Email					
Medicare Number	_____ IRN ____ Valid To ____ / ____				
Concession Number			Expiry Date	__ / __ / __	Type
Dept. Veterans' Affairs Number				Class	GOLD
Occupation				Student	Yes / No
Would you like to be added to our SMS APPOINTMENT reminders system?				Yes / No	
Would you like to be added to our recall/reminder system?				Yes / No	

MEDICAL HISTORY		
Usual/Previous Treating Doctor		Practice
Allergies/ Adverse Drug Reactions	Yes / No	(If yes, please list item, reaction and severity)
Current Medications		
Smoking Status	(please circle) Non-smoker Ex-smoker Smoker	
If current smoker	How many cigarettes per day:	Year started:

<i>If ex-smoker</i>	(please circle) Light Moderate Heavy			
	<i>Ex Smoker (please state)</i>	Year started:	Year stopped:	
Current Alcohol Intake	How many days per week:	Standard drinks consumed on any given day:		
Past Alcohol Intake	(please circle) Nil Occasional Moderate Heavy			
Mother Alive	Yes / No / Unknown	Age of Death:	Cause of Death:	
Father Alive	Yes / No / Unknown	Age of Death:	Cause of Death:	
Relevant Family History	Please list any chronic health conditions: Mother: _____ Grandparents: _____ Father: _____ Siblings: _____			
Personal Medical History <i>(please list or circle relevant information)</i>	Any recent Hospital Admissions and/or Operations/Procedures:			
	Chronic health conditions: Diabetes Heart Disease Cancer Stroke Asthma/Lung Issues Mental Health Issues Other: _____			
	Have you had any of the following removed: Appendix Gallbladder Tonsils/Adenoids Other: _____			
Immunisations <i>(please tick box if up to date & specify date administered if known)</i>	Tetanus <input type="checkbox"/>	Date __/__/____	Pneumococcal23 <input type="checkbox"/>	Date __/__/____
	Hepatitis A <input type="checkbox"/>	Date __/__/____	Hepatitis B <input type="checkbox"/>	Date __/__/____
	Whooping Cough <input type="checkbox"/>	Date __/__/____	Influenza <input type="checkbox"/>	Date __/__/____
<i>For Females Only</i>	Pap Smear	Date of last exam: __/__/____	Result: Negative / Positive	
	Hysterectomy	Yes / No	If yes, Date: __/__/____	
	Mammogram	Yes / No	If yes, Date: __/__/____	
<i>For Children Only</i>	Is the patient up to date for childhood immunisations? Yes / No			

NEXT OF KIN / EMERGENCY CONTACT			
First Name		Surname	DOB: / /
Address (if different to patient)			
Phone Number		Relationship	
Patient or Parent/Guardian Signature		Date	

Please notify our Reception of any cancellations of appointments.

We ask for at least one hours notice prior to appointment cancellation or a fee will be charged for non-attendance.