SPRINGWOOD

Shop10, 49-51 Cheek Ave
Gawler East SA 5118
Phone: 85231880

NEW PATIENT FORM – NURSE			
MEDICAL HISTORY			
Allergies	Yes / No	(If yes please list) _____ _____	
Current Medications	Yes / No	(If yes please list) _____ _____	
Smoking History *(Circle & Complete)*	Have you ever smoked cigarettes?	Yes / No	
	Smoker	Year Started:	Average cigarettes per day:
	Ex-Smoker	Year Started:	Year Stopped:
		Frequency: Light	Moderate Heavy
Alcohol History	Have you ever drunk alcohol?	Yes / No	
	Current Intake	Average days per week:	Drinks per day:
	Past Intake	Year Started:	Year Stopped:
		Frequency: Light	Moderate Heavy

Family History				
Usual/Previous treating Doctor			Practice	
Relevant Family History	Please list any history of chronic health conditions below:			
	Mother		Grandparents	
	Father		Grandparents	
Father Alive?	Yes / No / Unknown	Age of Death:	Cause of Death:	
Mother Alive?	Yes / No / Unknown	Age of Death:	Cause of Death:	
PERSONAL MEDICAL HISTORY *(Please list or circle relevant information)*	Have you had any recent Hospital Admissions/Operations/Procedures: Yes / No (If yes please list with dates) _____ _____ _____ _____			
	Have you been diagnosed with any of the following chronic health conditions? Diabetes Heart Disease Cancer Stroke Asthma/Lung Issues Mental Health Other: _____			

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NEW PATEINT FORM – NURSE Cont.			
IMMUNISATIONS *(Please include dates if known)*	If this form is for a child, are they up to date on the Australian vaccination schedule? Yes / No		
	(If no please indicate from what age/date the last vaccines were administered) _____		
	For adults *(over the age of 18)* please indicate which vaccines you have received bellow:		
	Tetanus ☐ Date____/____/_____	Pneumococcal23 ☐	Date____/____/_____
	Hepatitis A ☐ Date____/____/_____	Hepatitis B ☐	Date____/____/_____
	Whooping Cough ☐ Date____/____/_____	Influenza ☐	Date____/____/_____

WOMEN'S HEALTH			
Pap Smear	Date of last exam: ____ /____ /_____		Result: Negative / Positive
Hysterectomy	Yes / No	If yes, Date: ____ /____ /_____	
Mammogram	Yes / No	If yes, Date: ____ /____ /_____	
I hereby declare that the details I have provided are true and correct at the time this form was completed. I understand that it is my responsibility to update the practice and its staff should any of the information provided in this form change or require updating at any point from this moment onwards.			
SIGNATURE		**DATE**	/ /