CROWS NEST medical practice

PERSONAL INFORMATION SHEET

To ensure accurate medical records, PLEASE COMPLETE ALL AREAS ON THIS FORM
Present Medicare Card and Photo ID when handing this form to reception staff.

Title: Mr Mrs Miss Ms Mstr Dr Other (Circle) Gender: Female/Male/Other

Surname:……First Name:……..…Preferred……

Date of Birth: __ __ / __ __/ __ __ Ethnic Background: …… (1 only)

ADDRESS: …… Suburb: ……Postcode: ….....

Email: …….. (To contact when phone not available)

Consent to SMS reminder to mobile **Yes / No** - Appointments, Clinical reminders, Clinical communication and Health awareness

Phone (H):__ __ __ __ __ __ __ __ __ __ __ (M):__ __ __ __ __ __ __ __ __ __ __ Phone (W):__ __ __ __ __ __ __ __ __ __ __

MEDICARE No: __ __ __ __ __ __ __ __ __ __ Ref. No. in front of name: __ Expiry Date: __ __ / __ __

Full Pension Card Number: __ __ __ __ __ __ __ __ __ __ Expiry: __ __ / __ __

Veterans' Affairs Number: __ __ __ __ __ __ __ __ __ __ Card Colour: …… (If white) Condition: ……

Private Health Fund: _____ No: _____ Expiry: __ __/

Occupation: _____ Unemployed: _____

If completing this form for a child, please also fill in the details of Mother and Father.

Mother's Surname: _____ first Name: _____

Date of Birth: __ __ / __ __ / __ __ Mobile (if different from above) __ __ __ __ __ __ __ __ __ __

MEDICARE No: __ __ __ __ __ __ __ __ __ __ Ref. No. in front of name: __ Expiry Date: __ __ / __ __

Father's Surname: _____ first Name: _____

Date of Birth: __ __ / __ __ / __ __ Mobile: __ __ __ __ __ __ __ __ __ __

MEDICARE No: __ __ __ __ __ __ __ __ __ __ Ref. No. in front of name: __ Expiry Date: __ __/__ __

NAME OF EMERGENCY CONTACT: _____

Relationship to Patient: Phone (H):__ __ __ __ __ __ __ __ __ __ (M): __ __ __ __ __ __ __ __ __ __

NAME OF Next of Kin (NOK): _____

Relationship to Patient: _____ Phone (H):__ __ __ __ __ __ __ __ __ __ (M):__ __ __ __ __ __ __ __ __ __

If accept that if I do not attend my appointment or fail to give 2 hour notice to cancel my appointment, that I may incur a Non-attendance fee of $50. I am also aware if I run more than 20 minutes late to my appointment that I may need to reschedule my appointment.

Patient signature: _____ Date: __ __ / __ __/ __ __

Your medical record is a confidential document. It is the policy of this Practice to maintain security of personal health information at all times and to ensure that this information is available only to authorized members of staff.

MEDICAL HEALTH SUMMARY

To ensure accurate medical records, PLEASE COMPLETE ALL AREAS ON THIS FORM

PATIENT NAME: _____ DOB __ __/__ __/__ __ __

Known Allergies: _____

Please list all CURRENT MEDICATIONS you take: If none (Circle)

_____
_____
_____

Please list all CURRENT MEDICAL CONDITIONS you have if any: If none (Circle)

_____
_____
_____

Please list any significant PAST MEDICAL CONDITIONS or reasons for hospitalization if any: If none (Circle)

_____
_____
_____

Do you have a family history of the following conditions? Unknown (Circle) (e.g. adopted)

Mother alive? (Circle) Y / N If no – what age did they die? _____ Cause of death _____

Father alive? (Circle) Y / N If no – what age did they die? _____ Cause of death _____

	Diabetes	Hypertension	Ischaemic Heart Disease	Stroke	Depression	Asthma	Cancer (specify type)	Other Condition
Mother								
Father								
Brother								
Sister								

Do you smoke? No / Yes If Yes, how many cigarettes do you smoke per day? _____

How much alcohol do you consume? Number of days per week _____ Number of drinks per session _____

Women's Health	Women and Men	Men's Health
When was your last cervical smear?	When was your last blood test?	When was your last prostate / PSA test?
Date: __ __/__ __/__ __ or	(circle) Sugar / Cholesterol	Date: __ __/__ __/__ __ or
(circle) Never / Not require	Date: __ __/__ __/__ __ or Never (circle)	(circle) Never
Were the results:	Were the results:	Were the results:
(circle) Normal / Abnormal	(circle) Normal / Abnormal	(circle) Normal / Abnormal
If Path group known please list	If pathology group known please state:	If pathology group known please state:
_____	_____	_____