Tannum Family Practice

Patient Information Form

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Title: Mr Mrs Miss Ms Other		**First Name:**		
Surname:		**Known As:**		
D.O.B: / /		**Sex:** Male / Female		
Do you identify as any of the following:	Aboriginal	Torres Strait Islander	Both	Neither
Residential Address:				
Postal (If Different from Above):				
Home Phone:		**Work Phone:**		
Mobile Phone:		**Email:**		
Marital Status: □ Single □ Defacto □ Married □ Separated □ Divorced □ Widowed				
Occupation:				

Medicare Number:		**Ref:**	**Exp:** /
Pension Card Type (Please Circle)			
Pensioners Concession	**Health Care Card**	**DVA:**	**Gold White**
Concession Card Number:		**Exp:** / /	

Next of Kin:

Name:	**Relationship:**
Residential Address:	
Home Phone:	**Mobile Phone:**

Emergency Contact:

Name:	**Relationship:**
Residential Address:	
Home Phone:	**Mobile Phone:**

Social and Lifestyle History:

Do you smoke?	**Yes**	**No**
If yes, how many cigarettes per day?		
Have you ever tried to quit smoking?	**Yes**	**No**
Do you drink alcohol?	**Yes**	**No**
If yes, how many drinks per day?		
If yes, how many days per week?		

Females:

When did you last have?			
Pap Smear	**Date:**	**Not sure**	**Never**
Mammogram	**Date:**	**Not sure**	**Never**
Have you ever been pregnant?			

Males:

When did you last have?			
An overall check up	**Date:**	**Not Sure**	**Never**

Allergies/Any known Allergies:	Yes	No
Details:		

Have you experienced any of the following conditions? (Please tick)

Medical Condition	Yes	No		Yes	No
Asthma			Arthritis		
Anxiety			Blood Pressure (Low/High)		
Blood Disorders			Blindness / Glaucoma		
Broken Bones / Fracture			Cancer		
Chemotherapy			Diabetes		
Depression			Eczema		
Epilepsy			Heart Disease/Heart Attack		
Hepatitis – A, B, C			HIV / AIDS		
Hay fever			Kidney Problems		
Liver Problems			Post-Traumatic Stress		
Stroke			Mental Health Issues		
Other (Please specify):					

Family History: Please list any medical conditions any family members have been diagnosed with, or suffered from:

Condition:	Yes/No	Details:
Diabetes		
Asthma		
Heart Disease		
Cancer (Please specify)		
Other:		

Children's Immunisations:

Do you believe your child's vaccinations/immunisations are up to date?	Yes	No

* Please supply your child's immunisation book for verification.

Is there any other information that you believe would be beneficial to the treatment or that may have an effect on the medical treatment you will be provided?

_____

_____

Tannum Family Practice has a cancellation policy whereby if you fail to cancel an appointment or do not show for an appointment, you will be charged a $45 missed appointment fee which is not covered by medicare.

Please advise us of any cultural or ethical beliefs that we should be aware of in our care.

Our email system is not continuously monitored, please do not send urgent requests through this method, always ring reception.

Signature of Patient/Guardian: _____ **Date:** _____