FRASER SHORES MEDICAL CENTRE
Experienced. Committed. Quality Healthcare.

NEW PATIENT INFORMATION SHEET

Mr / Mrs / Ms / Miss / Master (please circle) Male / Female / Transgender (please circle)

SURNAME:.....

FIRST NAME:.....

DATE OF BIRTH:..... COUNTRY OF BIRTH:.....

HOME ADDRESS: .....

POSTAL ADDRESS: .....

HOME PHONE:.....WORK: ..... MOBILE: .....

MEDICARE NUMBER:..... REFERENCE NO: ..... EXPIRY DATE:.....

PENSION/HEALTH CARE CARD NUMBER:..... EXPIRY DATE: .....

DVA NUMBER:..... EXPIRY DATE: .....

ARE YOU ABORIGINAL? YES / NO

ARE YOU TORRES STRAIT ISLANDER? YES / NO

OTHER CULTURAL BACKGROUND / ETHNICITY YES / NO ..... (please specify)

MARITAL STATUS: MARRIED / SINGLE / DEFACTO / DIVORCED / WIDOWED

DO YOU HAVE ANY ALLERGIES? YES / NO (if yes please state what types below)

.....

Occupation: .....

EMERGENCY CONTACT DETAILS

NAME: .....RELATIONSHIP:.....

ADDRESS:.....POSTCODE:.....

PHONE NUMBER: ..... MOBILE:.....

PREVIOUS OPERATIONS: YEAR: .....OPERATION: ..... YEAR: .....OPERATION:.....

YEAR: .....OPERATION:..... YEAR: ..... OPERATION: . .....

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ASTHMA☐ BREASTCANCER☐ BOWEL/COLON CANCER☐ DEPRESSION☐ DIABETES☐ EPILEPSY☐

HEARTPROBLEMS☐ HIGH BLOOD PRESSURE☐ KIDNEY DISEASE☐ MELANOMA☐ STROKE☐

OTHER CANCER; Please detail: .....

FAMILY HISTORY

MOTHER:

ASTHMA☐ BREASTCANCER☐ BOWEL/COLON CANCER☐ DEPRESSION☐ DIABETES☐ EPILEPSY☐

HEARTPROBLEMS☐ HIGH BLOOD PRESSURE☐ KIDNEY DISEASE☐ MELANOMA☐ STROKE☐

OTHER CANCER; Please detail: .....

IS YOUR MOTHER STILL ALIVE: YES☐ NO☐ IF NO, AGE AT PASSING?..... CAUSE OF DEATH: .....

FATHER:

ASTHMA☐ BREASTCANCER☐ BOWEL/COLON CANCER☐ DEPRESSION☐ DIABETES☐ EPILEPSY☐

HEARTPROBLEMS☐ HIGH BLOOD PRESSURE☐ KIDNEY DISEASE☐ MELANOMA☐ STROKE☐

OTHER CANCER; Please detail: .....

IS YOU FATHER STILL ALIVE: YES☐ NO☐ IF NO, AGE AT PASSING? ..... CAUSE OF DEATH: .....

OTHER IMMEDIATE FAMILY MEMBERS WHO HAVE, OR HAVE HAD, ANY OF THE ILLNESSES LISTED ABOVE?

RELATIONSHIP	ILLNESS	RELATIONSHIP	ILLNESS
.....	.....	.....	.....
.....	.....	.....	.....

SOCIAL HISTORY

ARE YOU A CENTRELINK REGISTERED CARER? YES ☐ NO ☐

DO YOU HAVE A CARER? YES ☐ NO☐

IF YES CARER'S NAME: .....

ADDRESS: .....

CONTACT: PHONE: .....MOBILE:.....

ALCHOL CONSUMPTION:

DO YOU DRINK ALCOHOL? YES☐ NO☐ HOW MANY DAYS PER WEEK? ..... HOW MANY PER DAY?.....

PREVIOUSLY: NIL☐ LIGHT☐ MODERATE☐ HEAVY☐

SMOKING:

DO YOU CURRENTLY SMOKE? YES☐ NO☐ HOW MANY DAYS PER WEEK? ..... HOW MANY PER DAY?.....

PREVIOUSLY: NIL☐ LIGHT☐ MODERATE☐ HEAVY☐

We have introduced a **DO NOT ATTEND FEE OF $20.00 (cash).** If no notice or continual missed appointments happen, you will be charged this fee. You will be required to pay this fee before another appointment can be made. There is NO Medicare rebate**.**

PATIENT SIGNATURE: ..... DATE: .....