

Office Use Only:

- Form Completed
- NP
- Existing



This information is private and confidential and is for use in your clinical file only.

PATIENT DETAILS

Mr Mrs Ms Miss Dr **Surname:** _____ **Given Name:** _____ **Middle Name:** _____

Date of Birth ____/____/____ **Ethnicity:** Australian Aboriginal TSI ATSI Other _____

Country Of Birth _____

Residential Address: _____ **Town:** _____ **Postcode:** _____

Postal Address: *(if different to home)* _____

Phone: _____ **Mobile:** _____ **Business:** _____

Email Address: _____ **Do you wish to receive electronic newsletters:** Yes No

Medicare No: _____ **Ref #** *(next to name)* _____ **Expiry:** _____

Veterans Affairs No: _____ Gold White - Condition/s: _____

Pension/Healthcare Card No: _____ **Expiry:** _____

Do you have private health care fund? Yes No **Fund Name:** _____ **Fund Number:** _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Current Medications and Doses: _____

Please list any known allergies and your reactions or list nil known if none: _____

Please list any operations or previous illnesses: _____

SOCIAL HISTORY - Please check the most appropriate answer fill out all other areas

Marital Status: Single Married De-facto Divorced Widowed Separated

Recreational Activities: _____

Accommodation: Own Home Rental Relatives Nursing Home Hostel Homeless Other

Lives with: _____ **Is Carer:** Yes No **Has Carer:** Yes No

If Yes, Carer Name: _____ **Address:** _____

Contact No: _____

Alcohol Consumption: Do you drink alcohol? Yes No If yes how much _____

Past Alcohol Consumption: Nil Light Moderate Heavy

Smoking: Do you smoke? Yes No If yes how many per day ? _____

Past Smoking History: Nil Light Moderate Heavy Which year did you stop smoking? _____

What is your Occupation? _____ **Past Occupation:** _____

FAMILY HISTORY - Please check the most appropriate answer fill out all other areas

Have you ever had: Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems
 Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

Family History: Unknown (eg Adopted) No significant family history Other – see list below

Mother: Still alive: Yes No If no Age at Death: _____

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems
 Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

Father: Still alive: Yes No If no Age at Death: _____

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems
 Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

Other immediate family members significant illness: _____

Do you know your blood group? Yes No If yes, what group are you? _____

Cardiovascular

(1) When was your blood pressure last taken?

MM/YYYY

_____ / _____

Unsure Never

(2) When were your cholesterol and triglycerides(fats in the blood) last tested?

MM/YYYY

_____ / _____

Unsure Never

Exercise (in the past 7 days)

(1) How many times did you walk briskly for at least a total of 30 minutes, eg. for recreation, exercise or to get to and from places?

None 1–2 x 3–4 x 5–7 x

(2) How many times were you moderately active in other ways (just as active as walking briskly)for at least a total of 30 minutes, eg. Digging in the garden, golf, dancing, or tennis?

None 1–2 x 3–4 x 5–7 x

(3) How often were you vigorously active for at least a total of 30 minutes, eg. jogging or running, tennis, swimming, bike riding, aerobics or fitness exercises?

None Once Twice 3 or more times

PLEASE TURN OVER

Nutrition

(1) How many portions of fruit and vegetables do you usually eat each day?

- None 1–2 3–4 5–6 7 or more

Examples of a single portion:

Fruit

- 1 medium size apple, banana, orange or quarter rockmelon
- half a cup of fruit juice
- 4 dried apricots or 1 1/2 tablespoons of sultanas
- 1 cup of canned or fresh fruit salad

Vegetables

- half a cup of cooked vegetables (75 g)
- 1 medium potato
- 1 cup of salad vegetables

Mental Health

(1) During the past month have you often been bothered by feeling down, depressed or hopeless?

- Yes No Unsure

(2) Do you feel that you have someone to talk to or support you if you need to?

- Yes No Unsure

Immunisation

(1) When was your last tetanus booster?

MM/YYYY

____/____/____

- Unsure Never

(2) Have you had 3 doses of polio vaccine (drops or injection)?

- Yes No Unsure

(3) Have you ever had immunisations for

Hepatitis ____/____/____

Influenza ____/____/____

Pneumonia ____/____/____

Skin Cancer

(1) Do you protect yourself from the sun when outdoors?

A.

- wear protective clothing
 always often
 sometimes rarely
 never

B.

- use sunscreen creams
 always often
 sometimes rarely
 never

Have you ever had your skin checked? Yes No

PLEASE TURN OVER

Medications

(1) Do you regularly use any non-prescription drugs (eg. over-the-counter)?

Yes which ones? Please list:

No

(2) Do you regularly use any herbal or other natural medicines?

Yes which ones? Please list:

No

(3) Do you use any recreational drugs, eg..marijuana, speed, ecstasy?

Yes which ones? Please list:

No

Do you ever have trouble with your bladder/urine flow?

Yes No Unsure

Women Only

Have you had a Pap test in the past 2 years?

Yes No Unsure

Is there any additional health information that you would like to add?

This questionnaire remains private and confidential.
The information gathered in this questionnaire is for use in your personal medical file only.

**PLEASE FILL OUT THE DETAILS AND RETURN TO RECEPTION AT WOLLOMBI MEDICAL PRACTICE
AT LEAST 2 DAYS PRIOR TO YOUR APPOINTMENT**

THANK YOU