BELMORE ROAD MEDICAL CENTRE

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

(Return page 1 to Reception and take pages 2&3 into the doctor's room)

TITLE: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast. ☐ Other ☐

SURNAME: ____________________ **NAME:** ____________________

PREFERRED NAME: ____________________ **DATE OF BIRTH:** ____________________

ADDRESS: ____

CONTACT NUMBERS: HOME: ____________________ **MOBILE:** ____________________

EMAIL ADDRESS: ____

Would you like to register for MyHealth Record? Yes☐ No☐

Consent to upload health/event summary? Yes☐ No☐

OCCUPATION: ____________________ **WORK COVER INJURY:** Yes☐ NO☐

DVA/MEDICARE #: ____________________ **REF #:** __________ **EXPIRY:** __________

Are you an overseas student? Or ineligible for Medicare? Yes/No (If yes, please speak to reception)

HEALTHCARE/PENSION CARD # ____________________ EXPIRY: __________

PLEASE SPECIFY: HEALTHCARE CARD ☐ PENSION CARD ☐ OTHER ☐

NEXT OF KIN:

NAME: ____________________ **RELATIONSHIP:** ____________________

CONTACT NUMBER: ____

EMERGENCY CONTACT: (same as above ☐)

NAME: ____________________ **RELATIONSHIP:** ____________________

CONTACT NUMBER: ____

Australia is genuinely a multicultural society. In order to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds we request you to specify if you identify as someone from a culturally and/or linguistic diverse background.

☐YES Please elaborate i.e. – country of birth

To assist with health initiatives – do you identify as Aboriginal or Torres Strait Islander?

☐YES Aboriginal ☐YES Torres Strait Islander ☐YES Aboriginal & Torres Strait Islander

Would you like to be contacted via SMS for appointment reminders, recalls, test reminders and other medical services we offer?
YES☐ NO☐

SEE BACK OF CLIPBOARD for Privacy Policy, Patient Consent & e-mailing of Health Information
By signing below you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.
I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my consent will be obtained.
I give my permission for my personal information to be collected, used and disclosed as described above (including via SMS to my mobile phone number). I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
I acknowledge that I have directly requested the transfer of the health information listed below by Email. I understand and accept that the risks have been explained to me – that I have my personal information transferred without encryption – to the email address named above - and that Belmore Road Medical Centre staff and doctors are not responsible for the security of information once the email has been sent.
Only the documents requested will be transferred. This consent applies to those documents only.

PATIENT SIGNATURE: ____________________ DATE: _______________

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TITLE: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast. ☐ Other ☐

SURNAME: ______________________ **NAME:** ______________________

PREFERRED NAME:______________________ **DATE OF BIRTH:**______________________

CURRENT MEDICATIONS: (*including over the counter medications, vitamins and minerals***)**

Please list:______________________

____

____

____

ALLERGIES & SENSITIVITIES:

Do you have any allergies and/or are you sensitive to any drugs or dressings? YES☐ NO☐

Please list:______________________

____

SOCIAL & LIFESTYLE HISTORY

ALCOHOL: Non-drinker ☐ Drinker ☐

How often do you have a drink containing alcohol:

Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-4 times/week ☐ 4 times +/week ☐

How many standard drinks containing alcohol would you have on a typical day:

1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10+ drinks ☐

☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

TOBACCO: I have never smoked ☐ Ceased smoking ☐ Year .... Smoker ☐ ......per day/week

PHYSICAL ACTIVITY:

How many days per week do you usually do "at least" 10 minutes of VIGOROUS physical activity?

1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐ Never ☐

How many days per week do you usually do 20 minutes of VIGOROUS physical activity? E.g. Running, swimming, aerobics, tennis, bike riding

1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐ Never ☐

YOUR HEALTH HISTORY:

Weight:.......................(kgs) Height: ....(cm) Waist Measurement: .... (cm) *(if known)*

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If 50 years or older, have you had a test as part of the National Bowel Cancer Screening Program?

Yes ☐ No ☐

Do you or any members of our family have or have had any of the following? Y/N

Details:	Asthma	Diabetes	Hypertension	Cancer	Heart Disease	Depression
You						
Mother						
Father						

Other: If yes, please provide details**:** ______________________________

PAST ILLNESSES AND OPERATIONS

____

____

____

SKIN CHECK – do you have a regular skin check ?

Yes ☐ No ☐ Date of last check: **……………………..**

FEMALES: When did you last have a :

Cervical Screening: Date: ……………………… Not sure ☐ Never ☐

Breast Check: Date: ……………………… Not sure ☐ Never ☐

Mammogram: Date: ……………………… Not sure ☐ Never ☐

CHILDREN'S IMMUNISATIONS:

If completing this form for a child, are their immunisations up to date: Yes ☐ No ☐

I there any other information that you believe we should know that may affect or have an influence on the medical treatment/advice you will be provide with?

If Yes, please provide details: ______________________________

____

____

Would you like to be contacted via SMS for appointment reminders, recalls, test reminders and other medical services we offer?
YES☐ NO☐

PATIENT SIGNATURE: ______________________________DATE: ____________________