Montague Farm Medical Centre

New Patient Form

Title	**Mr Mrs Ms Miss**		**Gender: Male / Female**	
Surname				
First Name				
Date of Birth				
Street Address				
Suburb/ Post Code				
Home Phone				
Work Phone				
Mobile Phone				
Email				
Occupation				
Marital Status				
Ethnicity				
Medicare Number	**Ref no:**		**Exp Date**	
DVA Gold / White			**Exp Date**	
Pension Number			**Exp Date**	
Health Care Card No			**Exp Date**	
Private Health Cover				
Next of Kin	**Full Name:** **Relationship:** **Phone:**			
Emergency Contact	**Full Name:** **Relationship:** **Phone:**			

How did you hear about us? .....

Reminder Systems:

Our practice provides our patients routine preventive care reminders e.g. immunisations, annual health checks, skin checks and cervical screening (replacing Pap smear).

Do you wish to have any relevant health reminders sent to you by SMS?

☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander descent?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander

☐ Yes- Aboriginal & Torres Strait Islander ☐ No

Please Turn Over

Montague Farm Medical Centre — New Patient Form

To provide you the best care, it is essential that your health information is accurate & up to date.
Please assist us by completing the following:

SMOKING
Do you smoke? ☐ Yes ☐ No
If Yes, how many a day? _____ cigarettes/ cigars/ rolled tobacco
Have you considered quitting?
☐ Yes ☐ Maybe ☐ No
If you smoked previously, when did you quit?
_____

ALCOHOL
Do you drink alcohol? ☐ Yes ☐ No
If Yes, how many days a week do you drink?
_____
On a typical day that you drink alcohol, how many drinks would you have? _____
How often would you have more than 6 standard drinks? ☐ Everyday ☐ Every week
☐ Every month ☐ Never

Allergies to any medicines - _____
other - _____

Family Medical History
Do you know what illnesses run in your family? (eg heart disease, high blood pressure, diabetes, asthma, cancer, kidney problems, depression, stroke, high cholesterol, etc)
Father - _____ Maternal Grandfather - _____
Mother - _____ Maternal Grandmother - _____
Sisters/ Brothers - _____ Paternal Grandfather - _____
Children - _____ Paternal Grandmother - _____

Vaccinations: Have you had any of the following vaccinations? (Please Tick Box)

Flu vaccine ☐
Pneumonia vaccine (age 65+) ☐
Tetanus vaccine ☐
Gardasil (cervical cancer vaccine) ☐

Women's Health : When did you have the following checked?
Cervical Screening (females older than 25 yo should have a check every 5 years)
20_ _ / Never / Don't want any / had a hysterectomy Was it Normal? ☐Yes ☐No
Mammogram (females aged 50+ should have a check every 2 years)
20_ _ / Never / Don't want any / had breast cancer Was it Normal? ☐Yes ☐No
Bowel cancer screening (all aged 50+ should have a check every 5 years)
20_ _ / Never checked / Don't want any / had bowel cancer Was it Normal? ☐Yes ☐No

Men's Health : When did you have the following checked?

Prostate check (men aged 50+ should have a check every 2 year)
20_ _ / Never checked / Don't want a check / I have prostate cancer
Bowel cancer screening (all aged 50+ should have a check every 5 years)
20_ _ / Never checked / Don't want a check / I have bowel cancer

We undertake health checks for the elderly / children and 45-49 y/o patients
We provide comprehensive chronic disease care eg Diabetes / Heart Disease / Asthma

Please return this page to the receptionist as soon as you have filled it out so that the Doctor can see you promptly. Thank you

Office Use Only: Date: ___ / ___ / 20___ Comp: TS/TR/GB/MR