ESPERANCE FAMILY PRACTICE

Patient Registration Form PART A

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:	
Title:	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
Surname	
First Name	
Date of Birth □ Male □ Female □ Other	
Street Address Postal Address	
Suburb and Post Code	
Home Phone	
Work Phone	
Mobile Phone	
Email Do you consent to appointment reminders by SMS :	□ Yes □ No

Medicare Number Number patient is on card	#: #:	Expiry:
☐ DVA Gold ☐ DVA White (Please tick which)	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Private Health Cover	Name: #:	

Next of Kin and phone number: Relationship to patient.	
Emergency Contact. Name and phone number:	

Occupation of Patient.	

Patient Registration Form PART A cont'd

Reminder Systems

Our practice provides our patients with preventive care and early detection reminders

Do you wish to have any relevant health reminders sent to you?	
☐ Yes – by Mail ☐ Yes – by this Email_____ ☐ Yes – by SMS this mobile phone_____	☐ No
If we need to contact you what is your preferred method of contact:	
☐ Home Phone ☐ Mobile	☐ Mail ☐ Email
Are there any health concerns that you would like to receive information on? Is there any other information you believe we should know your health concerns?	

Patient Background

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.

Do you identify as someone from a culturally and/or linguistic diverse background?
☐ No ☐ Yes. Please elaborate:
To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?
☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait Islander

Signature: …… Date: ……

PART B

Your Health History

Do you have or have you had a history of the following? (please elaborate)
☐ Operations
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other
Do you have any allergies or are you sensitive to drugs or dressings?
☐ No ☐ Yes. Please elaborate:

Immunisations

Have you had the following immunisations? (list date where appropriate)			
Tetanus Booster	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis B	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis A	☐ Yes. Date:	☐ No	☐ Don't Know
Influenza	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ Don't Know
Polio	☐ Yes. Date:	☐ No	☐ Don't Know

Children's Immunisations

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

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

Family History

Have any members of your family had: (please elaborate)
☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Mental Illness
☐ Cancer

Social History

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ No. ☐ Yes. Number ____ day / ____ week or ☐ Ceased smoking
Alcohol	☐ No. ☐ Yes

Measurements

Height	_____ cm	Weight	_____ kg

For those 65 years and older:

When was the last time you were immunised?			
Influenza	Date:	☐ Not sure	☐ Never
Pneumococcal pneumonia	Date:	☐ Not sure	☐ Never

Females

When did you last have?			
Pap Smear	Date:	☐ Not sure	☐ Never
Breast Check	Date:	☐ Not sure	☐ Never

Males

Have you had?			
Overall Checkup	Date:	☐ Not sure	☐ Never
GDMP	Date:	☐ Not sure	☐ Never
MHP	Date:	☐ Not sure	☐ Never
TCA	Date:	☐ Not sure	☐ Never
Over 75 Year Health Assessment	Date:	☐ Not sure	☐ Never

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Signature: …… Date: ……..