Seymour Medical Clinic
'Healthy Country Life'

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New Patient Information Form

Section 1

If Patient is under 16 years	**Name of Parent or Guardian**		**Date of Birth / /**
Medicare		**Your number on card (next to your name)**	**Exp /**

Patient Surname		**Previous Surname (if any)**		
Given Name/s		**Preferred Name (if any)**		
Preferred Title	**Gender M F**	**Date of Birth / /**	**Marital Status**	
Street Address		**Town**	**Postcode**	
Postal Address		**Town**	**Postcode**	
Home Phone	**Work**	**Mobile**		
Email Address				
Medicare	**Your number on card (next to your name)**	**Exp /**		
Pension/HCC	**Expiry Date / /**			
DVA #	**Gold card White card**	**Exp / /**		
Private health Ins				
Emergency Contact	**Name**	**Phone**	**Relationship**	
Next of Kin	**Name**	**Phone**	**Relationship**	
Do you wish to identify as	**Aboriginal Y☐ N☐**	**Torres Strait Islander Y☐ N☐**	**Aboriginal & Torres Strait Islander Y☐ N☐**	
Do you wish to identify as	**A person with a culturally and / linguistically diverse background? If yes please tell us.**			
Is a translator required for your consultation? No ☐ Yes ☐				
Do you have any allergies or are you sensitive to drugs or dressings? No ☐ Yes ☐ Please elaborate				

TRANSFER OF HEALTH INFORMATION:

You may have regularly consulted with a GP at another practice and the health information held by that GP may assist us with your future health care needs. If you wish to have a summary of your health records, including your most recent test results, transferred to this practice our receptionist can assist you to arrange the transfer.

- **Please hand section 1 of this form to the receptionist .**
- **Section 2 is optional.**
- **If you choose to complete section 2 you can give to the receptionist - or to the Dr if you prefer.**

Please sign and date this form……Date……

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Section 2 / Page 1 of 2

We invite you to answer the following questions which will help to create your personal health file. However, these questions are optional and if you prefer only to discuss any of these topic directly with you doctor, we respect your choice. You can fill out some questions, all the questions, or no questions at all.

Patient's Name…….

Occupation……..

Your health history – do you have, or have you a history of:

- ☐ Operations _____
- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Hypertension _____
- ☐ Chronic illness _____
- ☐ Other _____

Immunisations – have you had the following immunisations?

Tetanus booster	**Date**	**☐ Don't know**	**☐ Have not had one**
Hepatitis B	**Date**	**☐ Don't know**	**☐ Have not had one**
Hepatitis A	**Date**	**☐ Don't know**	**☐ Have not had one**
Influenza	**Date**	**☐ Don't know**	**☐ Have not had one**
Pneumococcal	**Date**	**☐ Don't know**	**☐ Have not had one**
Polio	**Date**	**☐ Don't know**	**☐ Have not had one**

If completing this form for a child…are the childhood immunisations up to date? ☐ Yes ☐ No ☐ Don't know

Current Medications (including over the counter medications, vitamins and minerals):

_____

_____

☐ Tobacco _____day /week or …… ceased smoking ☐ date_____

☐ Alcohol drinks per day_____ or week_____or month_____

☐ Drug use_____

☐ Exercise_____

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Patient's Name…….
Family history – have any members of your immediate family (blood relatives) had:

- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Heart disease _____
- ☐ Chronic Illness _____
- ☐ Other _____

Height_____cms Weight_____kgs

Blood pressure – when was the last time your blood pressure was taken?_____

Sun Protection: How often do you use the following to protect you from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

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: when did you last have:

An overall check up	Date	☐ Not sure	☐ Never

Are there any health issues about which you would like more information?

Thank you very much for taking time to work through these questions. Please do not hesitate to speak with our staff if you have a question or comments about this form or any part of the service.

- **Please hand section 1 to the receptionist.**
- **Section 2 can be handed to the doctor or nurse if you prefer.**