Last Name……………………………….Given Names….………………………………… Preferred Name ……….…………..

Title  Mr  Mrs  Ms  Miss  Master  Dr Other ………………………………….

Date of Birth………………………….. Birth Sex (circle one): Female / Male / Other / Unknown

Gender Identity (circle one) Female / Male / Gender Diverse / Transgender / Different Identity……………................

**The following information will assist us in the planning and provision of the best possible care:**

Are you of Aboriginal and / or Torres Strait Islander origin?

 No  Yes Aboriginal  Yes Torres Strait Islander  Both, Aboriginal and Torres Strait Islander

What is your cultural background……………………………………………..

Country of Birth ………………………………… Is English your first language  Yes  No ………………………

If English is not your first language, do you require an interpreter  Yes  No

Street Address………………………………………………………………………………………………………………………….

Suburb…………………………………………………………………………………………………. Postcode…………………..

Home Phone No……………………………. Mobile………………………………………Work No………………………………

Medicare Card No           Ref  Expiry Date…………………..

 Health Care Card **or ** Pension Card ……………………………………… Expiry Date……………………

DVA Card No……………….… Expiry Date……………  Gold  White Specified Condition…………………………

Private Health Insurance  None  Basic  Intermediate  Top Hospital

Next-of-Kin……………………………………………Relationship………………………………..Phone No……………………..

Emergency Contact………………………………….Relationship………………………………..Phone No……………………..

**Privacy Statement**

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment (Enhancing Privacy Protection) Act 2012. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

** I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE**

Signature……………………………………………………………………………………………… Date………………………….

Smoking  Never  Ex-smoker – year stopped………………..  Smoker – how many/day…………………

Alcohol  Never  Drinker – how many days/week…….……….. How many std drinks/day………....................

What is your weight? ………….………….What is your height? …………….….. What is your waist? .………………………

**Females:** When did you last have?

Cervical Screening………..………  not sure  never Breast Screen…………..…….  not sure  never

Please list any medications that you are currently taking (including vitamins and herbal medicines):

Name of medication…………………………………………….Strength………………………..Daily Dose……………………...

Name of medication……………………………………………..Strength………………………..Daily Dose……………………..

Name of medication……………………………………………..Strength………………………..Daily Dose……………………..

Name of medication……………………………………………..Strength………………………..Daily Dose……………………..

Have you had any immunisations recently?  Flu Vaccine  Pneumococcal Vaccine  Other – please state:

……………………………………………………………………………………………………………………………………………

If child – are all childhood immunisations up to date?  Yes  No ……………………………………………………

Do you have any significant past medical history?  No  Yes………………………………………………….…

……………………………………………………………………………………………………………………………………………

Do you have any known allergies?  No  Yes …………………………………………………………………..

……………………………………………………………………………………………………………………………………………

Have you ever had an adverse reaction?  No  Yes …………………………………..………………………………

**Do you have any significant family history? ** Don’t know **** No **** Yes – please complete details below:

 Diabetes  Type 1  Type 2 Family Member…………………………………………………

 Cancer Type of Cancer…………………………. Family Member………………………………………………...

 Heart Disease Family Member………………………………………………………………………………………………...

 Hypertension Family Member………………………………………………………………………………………………...

 Stroke Family Member………………………………………………………………………………………………..

Other………………………………………………………………………………………………………………………………..



Mother – alive?  Yes  No Age at death………. Cause of death…………………………………….

Father – alive?  Yes  No Age of death………. Cause of death……………………………………

Marital Status…………………………………………….. Occupation…………………………………………………………….

Accommodation  Own home  Other ……………………………………………………………………………

Advanced Health Directive  No  Yes Relationship……………………………..Phone…………………………..

Enduring Power of Attorney  No  Yes Relationship………………………………Phone………………………