DUBBO FAMILY DOCTORS

New Patient information form (4 pages to be completed)

We are committed to providing our patients with the best quality care. To do this it is essential that your health record is accurate. Please complete the following details.

Title:	**Surname:**	**Given Names:**

Date of Birth:	**Gender:**

Home Address:	**Post Code:**

Postal Address:	**Post Code:**

Telephone Number:	**Home:**	**Work:**	**Mobile:**

Email Address:

Consent for contact via Email or SMS:

I hereby consent to Dubbo Family Doctors contacting me via Email or SMS for

- ☐ **Appointment reminders**
- ☐ **Clinical reminders**
- ☐ **Clinical correspondence (Results & Clinical messages)**
- ☐ **Health awareness (Leaflets & Database search)**

Signature:

Medicare Card Number:	**Ref Number:**	**Expiry Date:**

Pension, Health Care Card, or Veterans Affairs Number:	**Expiry date:**

Usual Doctor:

Who can we contact in an Emergency? **Name:**	**Contact Number:** **Relationship to you:**

Next of Kin Details: **Name:**	**Contact Number:** **Relationship to you:**

Do you have an Advanced Care Directive for end of life care? Yes ☐ No ☐

For more information please talk to your GP

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Cultural Background:

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No, Australian ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐

Yes, both Aboriginal and Torres Strait Islander ☐

Are you registered for the Closing the Gap (CTG) PBs Co-payment relief Yes ☐ No ☐

If No, please ask for further information

Other Cultural background:	**Country of Birth:**

Is English your first language? Yes ☐ No ☐ If not, do you require an interpreter? Yes ☐ No ☐

Please specify language:

IMPORTANT:

For All patients aged 16 years and over

In Accordance with Privacy Legislation we are unable to release any information either verbal or written without your consent.

1. **Do you wish to authorise a nominated person to access health information on your behalf**

   Yes ☐ No ☐

2. **Do you wish to authorise a nominated person to be able to collect Scripts/Pathology forms/Referrals & other paperwork on your behalf**

   Yes ☐ No ☐

If you ticked "Yes" to either of the above, please provide the following details for your nominated person

Name _____ Relationship to you _____

Phone contact number _____

Signature of patient or guardian_____ Date _____

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Reminder Systems:

As a standard part of our provision of high quality care, our practice provides our patients with preventative care and health review reminders e.g. immunisations, pap smears, check-ups, skin checks, Keep Well visits.

Do you provide consent to be contacted with health reminders relevant to you?

☐ **Yes** ☐ **No**

Your Health History:

Do you have or have you had a history of? (tick the relevant boxes)

Operations		**Strokes or mini-strokes**	
Heart attacks or angina		**Depression, anxiety, other mental illness**	
High blood pressure		**Arthritis**	
Asthma		**Osteoporosis**	
Emphysema, chronic bronchitis, or COPD		**Skin cancers**	
Diabetes		**Other**	

Allergies:

Do you have any allergies?

☐ **Yes (If yes, please list below)** ☐ **No**

Immunisations

Have you had the following immunisations?

Tetanus booster	**date**_____	☐ **Don't Know**	☐ **Haven't had one**
Whooping cough (Pertussis)	**date**_____	☐ **Don't Know**	☐ **Haven't had one**
Hepatitis B	**date**_____	☐ **Don't Know**	☐ **Haven't had one**
Hepatitis A	**date**_____	☐ **Don't Know**	☐ **Haven't had one**
Influenza	**date**_____	☐ **Don't Know**	☐ **Haven't had one**
Pneumococcal	**date**_____	☐ **Don't Know**	☐ **Haven't had one**
HPV (Gardasil / Cervarix)	**date**_____	☐ **Don't Know**	☐ **Haven't had one**
Zostavax (Shingles)	**date**_____	☐ **Don't Know**	☐ **Haven't had one**

Children's immunisations - if completing this form for a child, are their immunisations up to date?

☐ **Yes** ☐ **No**

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Current Medications:

What medications do you currently take? (Please include all medications including contraceptive pill, over the counter medications, vitamins and minerals):

_____

_____

_____

Family History: Have any members of your family had? (Please tick the relevant boxes)

Heart disease		Mental illness	
Asthma		Cancer	
Diabetes		Other health conditions	

Social history:

Occupation _____

☐ **Smoking (tobacco): _____ per day / week (circle the one applicable)**

☐ **Ceased Smoking – date: _____**

☐ **Alcohol: _____ drinks per day / week / month (circle the one applicable)**

☐ **Drug use: _____ (type and how often)**

Sun protection:

How often do you use the following to protect yourself from the sun when outdoors?

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

When was your last full skin check?

Females: When did you last have:

An overall check up **Date** _____

☐ **not sure** ☐ **never**

Cervical Screening **Date**_____

☐ **not sure** ☐ **never**

Mammogram **Date**_____

☐ **not sure** ☐ **never**

Males: When did you last have:

An overall check-up **Date** _____

☐ **not sure** ☐ **never**

Research and Quality Programs:

Our practice undertakes research, professional development, and quality assurance and improvement activities to improve patient care. Confidentiality and privacy will be maintained.

Do you consent to your health record being reviewed as part of the quality improvement activities at our practice?

☐ **Yes** ☐ **No**