

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

PERSONAL DETAILS

Today's Date: _____

Mr Miss Ms Mrs Dr

Surname: _____ Given Name: _____

Gender: Male Female

Date of Birth: ____/____/____

Home Address:

(Street Number) _____ (Street Name) _____

(Suburb) _____ (State) _____ (Postcode) _____

Contact Number: (Home) _____ (Mobile) _____

SMS Reminders: Yes No

Email Address: _____

Occupation: _____

EMERGENCY CONTACT DETAILS

Name: _____ Relationship: _____

Contact Number: _____

CULTURAL BACKGROUND

Knowing your cultural background can help us provide health care that meets your individual needs

Are you of Aboriginal or Torres Strait Islander background? Yes No

Is English your first language? Yes No

If No, do you require an interpreter? Yes No

If you require an interpreter, please specify language: _____

HEALTH CARE CARDS

MEDICARE

Card Number: _____ Reference Number (next to your name): _____

Expiry Date: _____

PRIVATE HEALTH INSURANCE

Health Fund: _____ Membership Number: _____

Level of Cover: _____

PENSION CARD HOLDER

Card Number: _____ Expiry Date: _____

HEALTH CARE CARD HOLDER

Card Number: _____ Expiry Date: _____

DVA CARD HOLDER

DVA Number: _____ Card Colour: _____

HOW DID YOU HEAR ABOUT US

- | | |
|---|---|
| Mail out <input type="checkbox"/> | Word of Mouth <input type="checkbox"/> |
| Google / Web <input type="checkbox"/> | Facebook <input type="checkbox"/> |
| Advertisement <input type="checkbox"/> | Current Patient <input type="checkbox"/> |
| Barry Plant Real Estate <input type="checkbox"/> | Coburg Districts Football Club <input type="checkbox"/> |
| Melb Uni Lightning Netball <input type="checkbox"/> | Hocking Stuart Real Estate <input type="checkbox"/> |
| Jetts Fitness <input type="checkbox"/> | Pascoe Vale Early Learning <input type="checkbox"/> |
| Pascoe Vale Dental <input type="checkbox"/> | |

Other: _____

MEDICAL HISTORY

Do you, or have you had, any of the following:	Yes	No	Details where relevant
Heart disease			
High blood pressure			
Stroke or brain haemorrhage			
Blood clots in legs or lungs			
High cholesterol			
Diabetes or raised blood sugar levels			
Kidney, urinary, or bladder disorders			
Stomach or bowel problems			
Liver disorders including hepatitis			
Any cancer or tumour, including skin cancers			
Eczema, Psoriasis, Dermatitis, other skin disorders			
Asthma, bronchitis or respiratory disorder			
Migraines			
Back or spinal problems or joint conditions			
Depression, anxiety, stress			
Any allergies?			
Any allergies to any medications?			

WOMEN ONLY – please complete this section

Do you, or have you had, any of the following:	Yes	No	Details where relevant
Complications with pregnancy or childbirth			
Problems related to menstruation or menopause			
Abnormal Pap test or mammogram			

When was your last Pap Test? _____

When was your last Mammogram? _____

IF THE PATIENT IS A CHILD ONLY – please complete this section

Does your child have, or have they had, any of the following:	Yes	No	Details where relevant
Asthma or other respiratory condition			
Cerebral palsy			
Depression, anxiety, stress			
Developmental or behavioural disorders, e.g. Speech disorder, ADHA, Aspergers			
Diabetes			
Eczema, Dermatitis, other disorders			
Epilepsy			
Intellectual Disability			
Physical disability			
Was there any problem during the pregnancy or delivery of this child?			
Do you have any concerns about your child's health or development?			
Are your child's immunisation up to date?			

LIFESTYLE RISK FACTORS (ADULTS ONLY)

SMOKING STATUS

Never Smoked

Ex-Smoker - When did you start smoking? _____ When did you stop? _____

Current Smoker - How many per day? _____

NUTRITION

Would you say you eat healthy?

Yes, all the time

Yes, most of the time

Yes, some of the time

No

ALCOHOL CONSUMPTION

Do you consume alcohol? Yes No

If Yes, how often?

Once a week

2 - 3 times a week

3 - 4 times a week

4 - 5 times a week

5 - 6 times a week

Everyday

PHYSICAL ACTIVITY

Do you participate in regular exercise? Yes No

If Yes...

1. What type? _____

2. How often?

Once a week

2 - 3 times a week

3 - 4 times a week

4 - 5 times a week

5 - 6 times a week

Everyday

MENTAL HEALTH

During the past 30 days, about how often did you feel...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless or fidgety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
So depressed that nothing could cheer you up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
That everything was an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIVACY AND CONSENT

Your medical record is a confidential document. When you register as a patient of our practice, you provide consent for our GPs and practice staff to access and use your personal information, so they can provide you with the best possible healthcare. It is always the policy of this practice to maintain security of personal health information in accordance with privacy laws, and to ensure that this information is only available to authorised people. More information about how the practice handles your personal health information is available in our privacy policy.

Our practice undertakes research, professional development and quality assurance improvement activities to improve patient care. We will always ask your consent before using any identifiable health information about you for these purposes.

We use a reminder system to improve the quality of your health care, and send out reminders for procedures such as vaccinations, Pap tests and other health reviews. You can opt out of participating in our reminder systems at any time.

We communicate with our patients via mail, SMS & email for the purposes of promoting our services that we think may be of interest to you. If you choose not to receive any such communication, please advise the Practice or use the “opt-out” facilities provided.

The doctors at our practice have been appointed as clinical teachers by the University of Melbourne. Please advise your doctor if you have concerns about having a student involved in your consultation.

TRANSFER OF HEALTH INFORMATION

You may have a health record at another practice. If you wish to have a copy or summary of your health records transferred to this practice, please ask reception.

I acknowledge that the information provided on this registration form is true and accurate and give consent for my personal information to be collected, used and disclosed as described above.

Signature of patient (or parent/guardian): _____ Date: _____

Print Name: _____