Narre Warren Medical Centre

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New Patient Form

Title: Master/Mr/Miss/Mrs/Ms	Given Names:	
Surname	D.O.B.	
Address:	Suburb: Postcode:	
Home Phone:	Mobile:	
Email:	Work Phone:	
Medicare:	Reference:	Expiry:
Pension:	Expiry:	Type:
Health Care Card:	Expiry:	

Do you identify as being Aboriginal or Torres Strait Islander? Yes/No
Do you require an interpreter? Yes/No
Consent to SMS contact/reminders from the clinic? Yes/No
Consent to contact by phone and email? Yes/No
Consent to have documents forwarded to others in the form of referrals/results? Yes/No

Next of Kin	**Emergency Contact**
Name:	Name:
Mobile:	Mobile:
Home Phone:	Home Phone:
Relation:	Relation:

Patient or Parent Signature: ____
Date: ____/____/________

*Here are Narre Warren Medical Centre, we aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use, and disclosure of your health information.

New Patient Medical History

Name ____

D.O.B. ________________________

Known allergies or anaphylaxis?

To what ____

Reaction ____

Current medications:

Name of Medication	Strength	Frequency

Previous operations or hospital admittance:

Year	Reason/ Surgery performed

Are you currently suffering from?

Condition	Yes or No	Condition	Yes or No
Heart problems		**High blood pressure**	
High cholesterol		**Varicose veins, clots or blocked arteries**	
Stomach ulcers		**Gall stones**	
Liver disease or jaundice		**Pancreatitis**	
Diabetes		**Cancer**	
Epilepsy/ fits		**Asthma/emphysema**	
Kidney/urine or bladder problems		**Prostate problems/impotence**	
Abnormal pap smear		**Sexually transmitted disease/AIDS**	

Social:

What	No. If you have quit, what year?	Yes	Usage
Cigarette smoking			
Alcohol consumption			
Recreational drug use			
Exercise			

Previous tests:

Test	Year if known	Regular or Irregular result
Cholesterol		
Blood Pressure		
Pap Smear		
Prostate Check		
Bowel Cancer Screen		
HIV/ STI Check		
Hepatitis Check		

Family History:

Has any relative suffered from	Relationship	Age of onset (if known)	Was this terminal?
High blood pressure			
High cholesterol			
Heart attack/angina			
Stroke			
Anaemia			
Blood disorder			
Tuberculosis			
Arthritis			
Diabetes			
Kidney disease			
Cancer or Tumor			
Asthma/emphysema			

Name: ____ **D.O.B.** ______________________________

Sign: ____________________________________

Disclaimer: All personal history is stored securely and will not be shared without your signed consent. All staff are thoroughly trained in keeping all patient information confidential. Please advise staff if you are uncomfortable sharing any of this information and we will notify the Dr.