Mawson Lakes Healthcare - New Patient Form

Title	Mr Mrs Ms Miss Gender: Male Female		
Surname			
First Name			
Date of Birth			
Street Address			
Suburb and Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Occupation			
Ethnicity			
Medicare Number	Person:	Expiry Date	
DVA Gold / White		Expiry Date	
Pension Number		Expiry Date	
Health Care Card No		Expiry Date	
Private Health Cover			
Next of Kin (Name and Number)			
Emergency Contact	(Name and Telephone number of the person we can contact if needed)		

How did you hear about us? …………………………………..……………………………

Reminder Systems:

Our practice provides our patients routine preventive care reminders e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you by SMS?

☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander descent?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander

☐ Yes- Aboriginal & Torres Strait Islander ☐ No

Please Turn Over

Office Use Only: Date: ___ / ___ / 20___ Comp: KA / TK

Mawson Lakes Healthcare - New Patient Form

To provide you the best care, it is essential that your health information is accurate & up to date.
Please assist us by completing the following:

SMOKING
Do you smoke? ☐ Yes ☐ No
If Yes, how many a day? _______ cigarettes/ cigars/ rolled tobacco
Have you considered quitting?
☐ Yes ☐ Maybe ☐ No
If you smoked previously, when did you quit?
____

ALCOHOL
Do you drink alcohol? ☐ Yes ☐ No
If Yes, how many days a week do you drink?
______
On a typical day that you drink alcohol, how many drinks would you have? ______
How often would you have more than 6 standard drinks? ☐ Everyday ☐ Every week ☐ Every month ☐ Never

Allergies to any medicines - ______________________________
other - ______________________________

Family History
Do you know what illnesses run in your family? (eg heart disease, high blood pressure, diabetes, asthma, cancer, kidney problems, depression, stroke, high cholesterol, etc)
Father - ______________________________
Mother - ______________________________
Sisters/ Brothers - ______________________________
Children - ______________________________
Grandparents - ______________________________

Vaccinations: What year did you last have the following immunisations? (please circle)

Flu vaccine	07 / 08 / 09 / 10 / 11 / 12 / 13 / 14 / 15 / 16 Never / Don't want any
Pneumonia vaccine (age 65+)	07 / 08 / 09 / 10 / 11 / 12 / 13 / 14 / 15 / 16 Never / Don't want any
Tetanus vaccine	07 / 08 / 09 / 10 / 11 / 12 / 13 / 14 / 15 / 16 Never / Don't want any
Gardasil (cervical cancer vaccine)	07 / 08 / 09 / 10 / 11 / 12 / 13 / 14 / 15 / 16 Never / Don't want any

Women's Health : When did you have the following checked?

PAP smear (females between 18-70yo should have a check every 2 years)
20_ _ / Never / Don't want any / had a hysterectomy Was it Normal? ☐Yes ☐No
Mammogram (females aged 50+ should have a check every 2 years)
20_ _ / Never / Don't want any / had breast cancer Was it Normal? ☐Yes ☐No
Bowel cancer screening (all aged 50+ should have a check every 2 year)
20_ _ / Never checked / Don't want any / had bowel cancer Was it Normal? ☐Yes ☐No

Men's Health : When did you have the following checked?

Prostate check (men aged 50+ should have a check every 2 year)
20_ _ / Never checked / Don't want a check / I have prostate cancer
Bowel cancer screening (all aged 50+ should have a check every 2 year)
20_ _ / Never checked / Don't want a check / I have bowel cancer

We undertake health checks for the elderly / children and 45-49 y/o patients
We provide comprehensive chronic disease care eg Diabetes / Heart Disease / Asthma

THANK YOU