

## NEW PATIENT INFORMATION FORM

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

### SECTION 1:

Could you please assist us by completing the following:

<b>Title – Please tick</b>	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Master <input type="checkbox"/> Other:			
<b>Surname</b>				
<b>First Name</b>		<b>Preferred Name</b>		
<b>Date of Birth</b>				
<b>Birth Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>Gender Identity - Please tick</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Gender Diverse <input type="checkbox"/> Transgender			
<b>Pronouns</b>	<input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs			
<b>Ethnicity (eg: Australian)</b>				
<b>Country of Birth</b>				
<b>Preferred Language</b>				
<b>Street Address</b>		<b>Interpreter Required</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Suburb</b>				
<b>Postal Address (if different)</b>		<b>Postcode</b>		
<b>Home Phone</b>				
<b>Mobile Phone</b>		<b>Work Phone</b>		
<b>Email</b>				
<b>Medicare Number</b>				
<b>DVA Card No.</b>		<b>Line No.</b>		<b>Expiry Date</b>
<b>Pension/Health Care Card</b>		<b>Colour</b>		
<b>Preferred Chemist</b>		<b>Expiry Date</b>		
<b>Next of Kin</b>	<b>Name:</b>  <b>Telephone Number:</b>  <b>Relationship to patient:</b>			
<b>Emergency Contact</b>	<b>Name:</b>  <b>Telephone Number:</b>  <b>Relationship to patient:</b>			

**Reminder Systems:**

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears (Cervical Screening Test).

**Do you wish to have any relevant health reminders sent to you?**

Yes – mail     Yes – email at this address: .....

**If we need to contact you what is your preferred method of contact:**

Home phone     Mobile phone     Mail

**To assist with health initiatives - are you Aboriginal or Torres Strait Islander?**

Yes – Aboriginal     Yes - Torres Strait Islander     Yes - Aboriginal & Torres Strait Islander     No

**Do you require the services of a translator?**

Yes     No

**Do you have any allergies or are you sensitive to drugs or dressings:**     Yes (If yes please list below)     No

<b>Item:</b>	<b>Reaction:</b>	<b>Severity:</b> (Mild, Moderate, Severe)

**Current Medications:**

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**SECTION 2:**

**Your Past Health History:**

Do you have or have you had any of the following?

- Operations (please list) \_\_\_\_\_
- Asthma
- Diabetes
- Hypertension
- Chronic Illness \_\_\_\_\_
- Other \_\_\_\_\_

**Immunisations:**

Have you had any of the following immunisations? (Please tick one box only and list date if known)

- |                 |   |                             |                                     |
|-----------------|---|-----------------------------|-------------------------------------|
| Tetanus Booster | <input type="checkbox"/> Yes. Date: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Hepatitis B     | <input type="checkbox"/> Yes. Date: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Hepatitis A     | <input type="checkbox"/> Yes. Date: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Influenza       | <input type="checkbox"/> Yes. Date: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Pneumococcal    | <input type="checkbox"/> Yes. Date: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |

**Children's Immunisations:**

If completing this form for a child are their immunisations up to date?

- Yes                       Copy provided to Practice
- No

**Family History:**

Is your Mother Alive:  Yes  No  
 Is your Father Alive:  Yes  No  
 Unknown:  Adopted  No Significant Family History

Has your mother ever had: (please elaborate)

**Mother:**  Diabetes  Hypertension  Heart Disease  Stroke  
 Asthma  Mental Illness  Cancer – Type: \_\_\_\_\_

Has your father ever had: (please elaborate)

**Father:**  Diabetes  Hypertension  Heart Disease  Stroke  
 Asthma  Mental Illness  Cancer – Type: \_\_\_\_\_

**Other Family Members:** \_\_\_\_\_

**Social History:**

Do you use any of the following: (list amount where appropriate)

Tobacco  No  
 Yes. Number per day: \_\_\_\_\_ Year Started: \_\_\_\_\_  
 Ceased Smoking

Alcohol  No – Non Drinker  
 Yes. How many standard drinks per day: \_\_\_\_\_  
 How many days per week would you consume alcohol: \_\_\_\_\_

Drug Use  No  
 Yes. Type \_\_\_\_\_ Frequency \_\_\_\_\_

**Occupation:** \_\_\_\_\_

Are you exposed to any of the following:

Asbestos  Radiation  Dust  Animals  Other: \_\_\_\_\_

**Sun Protection:**

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

Protective Clothing  Always  Often  Sometimes  Rarely  Never  
 Sunscreen Creams  Always  Often  Sometimes  Rarely  Never

**Females:**

**Cervical Screenings:**

Is your Cervical Screening (Pap Smear) up to date (last Screening must have been in the last 5 years):  Yes  No

When was your last recorded Cervical Screening (e.g.: what year): \_\_\_\_\_

Result, if known:  Negative  Unknown  Other: \_\_\_\_\_

Please indicate if you would like to be contacted about booking in for a Cervical Screening:  Yes  No

**Breast Check:**

When did you last have a Breast Check

Date: \_\_\_\_\_  Not sure  Never

Please indicate if you would like to be contacted about booking in for a Breast Check:  Yes  No

**Males:**

When did you last have an Overall Checkup?

Date: \_\_\_\_\_  Not sure  Never

**Signature of New Patient/Guardian:** \_\_\_\_\_

# Health Information Collection and Use Consent Form

**Patrick Street Family Practice**  
**Suite 1, 8-22 Patrick Street**  
**Stawell VIC 3380**

**P: (03) 5358 7555**

**F: (03) 5358 1669**

**E: [enquiries@psfamprac.com.au](mailto:enquiries@psfamprac.com.au)**

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

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.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For accreditation, research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases, disclosures as required by the court of law.
- For reminder letters which may be sent to you regarding your health care and management.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	<input type="checkbox"/>
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	<input type="checkbox"/>
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	<input type="checkbox"/>
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	<input type="checkbox"/>
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	<input type="checkbox"/>
<b>OR</b>	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	<input type="checkbox"/>

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Signed as Guardian for child:** \_\_\_\_\_

**Name: (printed)** \_\_\_\_\_

**Office Use Only**

<input type="checkbox"/> Received	Date: _____ Initial: _____
<input type="checkbox"/> Scanned	Date: _____ Initial: _____
<input type="checkbox"/> Section 1 Entered (by Admin Staff)	Date: _____ Initial: _____
<input type="checkbox"/> Section 2 Entered (by Clinical Staff)	Date: _____ Initial: _____