TITLE_____FIRSTNAME_____MIDDLENAME_____SURNAME_____

KNOWN AS (Nickname)_____DATE OF BIRTH_____SEX: M/F **GENDER**: Male/Female/Non-Binary

DO YOU IDENTIFY AS ATSI: YES / NO **Aboriginal / Torres Strait Island/ Both**

MARITAL STATUS: Single / Married / Widowed / Divorced / De facto / Separated
OCCUPATION:_____

CONTACT DETAILS:

HOMEADDRESS:_____

TOWN/CITY_____POSTCODE_____STATE_____

POSTAL ADDRESS (if different from above)
_____POSTCODE_____STATE_____

CONTACT NUMBERS:

Home _____ **Mobile** _____

Work _____**Fax**_____

Email _____

Can we contact you via SMS: Yes/No Can we contact you via EMAIL: Yes/No Do you participate in My Health Record: Yes/No

NEXT OF KIN	
Name:	Date of Birth:
Relationship to you:	
Address:	
Phone Number (Home):	Mobile:
EMERGENCY CONTACT IF DIFFERENT FROM NOK	
Name:	Date of Birth:
Relationship to you:	
Address:	
Phone Number (Home)	Mobile:

ETHNICITY	
Cultural Background (Ex. Australian, Sudanese, German):	
Country of Birth:	Year arrived in Aust:
Language Spoken at Home:	English Spoken**:** YES/NO Interpreter Required: YES/NO

MEDICARE NO:	**REF NO.** 1 2 3 4 5 6 7 8 9	**EXPIRY DATE:**

NOMINATED PAYER: Self Mother Father Other – Name:

CONCESSION CARD: Yes / No **Type –** Pension / Health Care / Commonwealth Seniors / Veteran Gold / Veteran White (list condition)

CARD NUMBER:	**EXPIRY DATE**:
HOSPITAL COVER: Yes/No Fund Name:	**Type:** Basic / Intermediate /Top
OVERSEAS STUDENT HEALTH COVER: Yes/No **NUMBER:**	**EXPIRY DATE:**

DO YOU HAVE ANY ALLERGIES? YES / NO

If yes, please list Nature of Reaction:

DO YOU HAVE ANY ADVERSE REACTIONS TO ANY MEDICATION? YES / NO

If yes, please list Nature of Reaction:

DO YOU SMOKE? YES / NO	Quantity per Day:	How long have you been smoking?
HAVE YOU PREVIOUSLY SMOKED? YES / NO	**DATE OF CESSATION (QUITTING)**	

DO YOU CONSUME ALCOHOL? YES / NO

If yes, how often do you consume alcohol? (please circle)	Less than Monthly / 1-2 days a month /1-2 days a week /3 – 4 days a week / 5–6 days a week /Everyday

How many standard drinks do you consume on a day drinking alcohol?

SOCIAL HISTORY: Do you live alone? YES / NO If no, who do you live with?

DO YOU HAVE ANY CHILDREN? YES / NO

If yes, how many and what ages?

DO YOU PARTICIPATE IN REGULAR PHYSICAL ACTIVITIES? YES / NO

If yes, what type?

What are you hobbies/ interests

PAST HISTORY: Do you suffer from any of the following

Diabetes / Asthma / Heart Problems / High Blood Pressure Stroke / Breast Cancer / Depression / Bowel Cancer / PVD (Vascular Disease) / Bleeding Disorders / Blood Clots

Does anyone in your family suffer from the above (please indicate relationship – e.g. mother, brother, etc.)

Any Surgical History? Estimated date MM/YY

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION: *Warwick Road Medical hae a legal and ethical duty to protect patient information under The Privacy Act 1988. I consent to the use of my personal health information by the above-named practice and other health providers involved in my medical treatment and health care. I consent to the disclosure of my personal health information by the above-named practice to other health providers directly or indirectly involved in my personal health care or medical treatment. I understand that the Doctors within the Practice are qualified General Practitioners.*

DATA SHARING CONSENT:

I have read and understand the overview of Data Sharing Policies used by Warwick Road Medical - YES / NO

NAME	**DATE**
SIGNATURE	**DOB**

Note: Referrals to medical specialists/hospitals require patient information to be correct and current. If your details are not up to date, there may be a delay in the referral process. Please take the time to complete the following to ensure a prompt timely response.