Bayside Family Medical and Musculoskeletal Practice
Patient Information Form

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Could you please assist us by completing the following?

Title - please circle	Mr Mrs Ms Miss Dr Other _____				
Surname		**First Name**			
Date of Birth					
Marital Status					
Street Address					
Postal Address					
Suburb and Post Code					
Home Phone	**Mobile Phone :**		**Work Phone:**		
Email (optional)					

We occasionally use SMS messages for appointment confirmation, appointment recalls and information about upcoming events at the Practice (e.g. Fluvax, Health check ups, Skin Cancer check ups). NO private medical details will be communicated in these messages.

I consent to receive information via SMS ☐

I do not consent to receive information via SMS ☐

Occupation **If Retired, please write occupation you retired from.**					
Country of Birth					
Medicare Number		**Ref No**		**Expiry Date**	
DVA Gold / White (Please circle)				**Expiry Date**	
Pension Number				**Expiry Date**	
Health Care Card Number				**Expiry Date**	

Private Health Cover	Health Fund _____ **Hospital cover:** Yes ( ) No ( ) **Extras cover:** Yes ( ) No ( ) **Ambulance cover:** Yes ( ) No ( )
Next of Kin / Emergency Contact Is this the person you would like us to contact in the event of an emergency ?	Name _____ Relationship _____ Contact phone _____Mobile_____
Second option emergency	Name _____ Phone _____ Relationship _____

Australia is a genuinely multicultural society. To tailor appropriate care for people from different nationalities and backgrounds, do you identify as from a culturally diverse and/or non- English speaking background?

If Yes, are you of or from?

☐ Aboriginal origin ☐ Torres Strait Islander Origin ☐ Both (ATSI) ☐ Neither

☐ Other cultural or ethnic background (please indicate)_____

Please present your Medicare card and any Concession cards to the front desk at every appointment.

_____ _____

Patient Signature Date

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Your Health History - Do you have or had a history of?

☐ Operations

_____

☐ Asthma

_____

☐ Diabetes

_____

☐ Hypertension

_____

☐ Chronic illness

_____

☐ Other

_____

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes (If yes please list below) ☐No

_____

_____

Immunisations - Have you had the following immunisations?

Tetanus booster	date_____	☐ Don't Know	☐ Haven't had one
Hepatitis B	date_____	☐ Don't Know	☐ Haven't had one
Hepatitis A	date_____	☐ Don't Know	☐ Haven't had one
Influenza	date_____	☐ Don't Know	☐ Haven't had one
Pneumococcal	date_____	☐ Don't Know	☐ Haven't had one
Polio	date_____	☐ Don't Know	☐ Haven't had one

Children's Immunisations - If completing this form for a child are their immunisations up to date?

☐ Yes ☐No ☐ Unsure

Current Medications (including over the counter medications, vitamins and minerals)

_____

_____

_____

_____

_____

_____

_____

Family History - Have any members of your family had?

☐ Diabetes

_____

☐ Asthma

_____

☐ Heart Disease

_____

☐ Mental illness

_____

☐ Cancer

_____

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Social History

☐ Tobacco: _____ day / week or Ceased Smoking - date _____

☐ Alcohol: _____ day / week / month (circle the one applicable)

☐ Drug use: _____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs

Blood Pressure: When was the last time your blood pressure was taken? _____

_____

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

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

For those 65 years and older: When was the last time you were immunised?

Influenza	Date_____	☐ not sure	☐ never
Pneumococcal pneumonia	Date_____	☐ not sure	☐ never

Females: When did you last have?

Pap smear	Date_____	☐ not sure	☐ never
Breast check	Date_____	☐ not sure	☐ never
Skin check	Date_____	☐ not sure	☐ never

Males: When did you last have?

An overall check up	Date _____	☐ not sure	☐ never
Skin check	Date_____	☐ not sure	☐ never

Do you have any health concerns you would like to receive more information on?

_____

_____

_____

_____

_____

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