PATIENT INFORMATION FORM -- Gladstone Park Medical Clinic

This form **MUST** be completed in **FULL** and returned to the receptionist before seeing the doctor.

Title	**Miss**	**Ms**	**Mrs**	**Master**	**Mr**	**Dr**
Surname						
First Name						
Date of Birth						
Street Address						
Suburb & Postcode						
Home Phone						
Mobile Phone						
Work Phone						
Email Address						

Please Circle

Do you wish to have any relevant health reminders sent to you? Yes No

Medicare Card No.	**#:**	**Ref ( )**	**Expiry:**
DVA Card No. **Gold or White** (Please Circle One)	**#:**		**Expiry:**
Pension Card	**#:**		**Expiry:**
Health Care Card	**#:**		**Expiry:**

Country of Birth:…….. Year of arrival in Australia……..

To assist with health initiatives – Are you an Aboriginal or Torres Strait Islander? (Please Circle**)**

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

1	**Next of Kin (Name)**	
	Relationship	
	Contact Number	
2	**Emergency Contact (Name)**	
	Contact Number	

Refugee/Asylum Seeker Status: Only complete if this is relating to you:

Is English the main language spoken in your home? (Please Circle) **Yes No**

If not, please note preferred Language spoken:_____

Do you require an interpreter? **Yes No**

Were you a Refugee or Asylum Seeker when you arrived in Australia?.....

Do you use any of the following:	
Tobacco	▫ No ▫ Yes – Number _____day/ _____ week ▫ Ceased Smoking _____ Year
Alcohol	▫ No ▫ Yes – Number _____day/ _____ week

How did you hear about this clinic? (Please Tick)		
○ Friends/Relatives	○ Internet	○ Work
○ Advertising	○ Drive By	○ Other

My Health Medical Record Authorization

My Health is a national digital health record system allowing Clinics and Doctors Australia wide to have access to patient information such as allergies, medical conditions, medication and treatments.

To benefit from this service, please sign authority below:

X_____ **Date**____/____/____

Do you have any current allergies? (Please Circle) **Yes** **No**

Have you had the following immunizations? (Please Circle)			
Tetanus Booster	**Yes**	**No**	**Don't Know**

(Please List)

Please list all current medications including over the counter medications, vitamins and minerals that you are taking:

Have any members of your family had: (Please Circle)	
▫ Heart Disease ▫ Asthma ▫ Diabetes	▫ Mental Illness ▫ Cancer ▫ Other

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Hepatitis B	**Yes**	**No**	**Don't Know**
Hepatitis A	**Yes**	**No**	**Don't Know**
Influenza	**Yes**	**No**	**Don't Know**
Pneumococcal	**Yes**	**No**	**Don't Know**
Polio	**Yes**	**No**	**Don't Know**

Please initial for entering details into Pracsoft: **and scanned into History:**

If completing this form for a child, are their immunizations up to date: (Please Circle) Yes No