ST KILDA ROAD MEDICAL CENTRE

Date: …. / …. / ….

Time:………………..

New Patient Registration and Medical History Sheet

☐ Dr M Sargeant ☐ Dr E C Wong ☐ Dr J. Wadsley ☐ Dr J. Zappia
☐ Dr D Oberklaid ☐ Dr N Kustura ☐ Dr F Dent ☐
☐ Dr I Devlin ☐ Dr D Pytharoulious ☐ Dr P Khinda ☐

Title: _____ **NAME:** ________________________________ ____________________
(Mr / Mrs / Ms / Miss / Dr.) (Surname) (First Name)

ADDRESS: ____

____ **Postcode:** __________

D.O.B: ____ / ____ / ________ **Occupation:** ________________________________

Contact Phone Numbers: **A.T.S.I. :**

(h): ______________________ ☐ **Aboriginal** ☐ **Torres Strait Islander**

(w): ______________________ ☐ **Aboriginal & Torres Strait Islander**

(m): ______________________(We **send** SMS appointment reminders – tick if you do NOT wish to receive. ☐)

Email Address: ____

(We may contact you via this email address for health reminders, newsletters or health promotion activities.
Tick if you do NOT wish to be contacted via email. ☐)

Next of Kin: __________________________________ **Relationship:** ______________

Contact phone number: __________________

Emergency Contact: (if different from Next of Kin) Name: __________________________________

Contact Number: ___________________________ **Relationship:** ________________

Medicare Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ **Ref No: (at the left of *patient's* name)** ____

Valid to: ____ / ____

☐	**Pension Card**	**Card Number:** _________________________	**Valid to:** ____ / ____
☐	**Health Care Card**	**Card Number:** _________________________	**Valid to:** ____ / ____
☐	**DVA**	**Card Number:** _________________________	**Valid to:** ____ / ____

Patients attending the practice who are under Workcover, Insurance Companies or TAC will be required to pay the private practice fees on the day and seek reimbursement back from either Workcover, TAC or their Insurance company; there may be out of pocket costs. Registered companies excepted.

Employer name:____

Address: ____

Contact person: __________________________ **Phone number:** ________________

How did you hear about us?

☐ Website ☐ Via a friend or relative ☐ Via a fellow worker
☐ Yellow Pages online ☐ Saw the sign ☐ Other (please specify)

See over the page for Medical History Questionnaire

ST KILDA ROAD MEDICAL CENTRE

Confidential Medical History Questionnaire

Please take a moment to complete this confidential information sheet, so that your doctor can provide you with the best possible care. If some of the questions seem too detailed or personal, feel free to skip them or leave the sheet blank if you prefer.

	Age at Death	Cause of Death
Mother Alive? ☐ Yes ☐ No		
Father Alive? ☐ Yes ☐ No		

Past Medical History

Please tick box and circle problem if you have ever had any of the following:

Anaemia/Bleeding Disorders
Asthma/Emphysema/Lung Disease
Seizures /Convulsions/Blackouts
Hepatitis/Liver Disease
Kidney Disease
Diabetes
Cancer/Tumour/Leukaemia
Arthritis

Deafness/Hearing Loss
Vision Problems
High Blood Pressure/Heart Disease
Digestive Problems/Bowel Disease
Psychiatric/Emotional Problems
Other Medical Problems not listed above
____

Splenectomy (removal of spleen)
Hysterectomy/
____
Past Surgery

Is there a history of any of the above illnesses in any member of your family? ☐ **Yes** ☐ **No**

☐ Father: ……………….. .. ☐ Mother:………………… ☐ Sister : ……………….. ☐ Brother:……………………

Is there a history of any other significant illness in the family? ☐ **Yes** ☐ **No**

If yes, indicate which family member, please provide details of condition ☐ Father ☐ Mother ☐ Sister ☐ Brother:

____

Do you take any medications regularly? ☐ **Yes** ☐ **No** Please list: ______________________________

____

Do you take any herbal remedies or vitamins? ☐ **Yes** ☐ **No** Please list Type taken: ____________________

Do you take recreational drugs? ☐ **Yes** ☐ **No**

Please list Type taken:____

IT IS EXTREMELY IMPORTANT TO COMPLETE THIS SECTION REGARDING ALLERGIES:

Please list Allergies' medication, food or other. i.e. anaphylaxis, rashes, swelling or other to: ☐ **No Known Allergies**

(a) ____________________ **(b)**____________________ **(c)**____________________

Type of reaction? (a)____________________**Severity of reaction:** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Type of reaction? (b)____________________**Severity of reaction:** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Type of reaction? (c)____________________**Severity of reaction:** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

____

Do you smoke? ☐ **Yes** ☐ **No** If so how many per day? ____

Do you drink alcohol? ☐ **Yes** ☐ **No** **If so how many days per week?** ______

How many standard drinks on each occasion? ___________

Do you do any regular exercise? ☐ **Yes** ☐ **No** If so, how often? ___________ What form of exercise?______________

For women,
What year was your last Pap smear? _____________ Are you currently pregnant? ☐ **Yes** ☐ **No** ☐ **Unsure**

Patient's Signature:……………………………………………………..

Thank you for your time in completing this important part of your medical file.