NAMBOUR MEDICAL CENTRE

How did you find out about the surgery? Yellow/White Pages, Family/Friends, Pharmacy, Employer, Google, Facebook

Please Circle: Mr/ Mrs/ Ms/ Mst/ Miss / Dr

First Name: ________________________ Middle Name: ____________________ Family Name: ___________________________

(pref name) ____________________________ D.O.B ________________________

Residential Address: ____

Suburb: ____ State: ______________________ Post Code: _________________

Postal Address (if different to your Residential Address): ____

Suburb: _______________________________________ State: _______________________ Post Code: _________________

Home Telephone: ( ) __________________ Work Telephone: ( ) __________________ Mobile: ________________________

Email Address ____

Do you consent to SMS reminders being sent to your mobile phone number Yes ☐ No ☐

Occupation: ____

Photo ID: ____ Number: ________________________________

Medicare Number: ____ Reference Number: _________ Exp date: _______________

Vet Affairs Number: ____________________________ Gold ☐ White ☐ Conditions: ________________________

Pension/Health Care Card Number: ________________________ Exp date: ____________

Private Health Insurance: Yes ☐ No ☐ Name of Health Fund: _______________ Number: _________________

Next of kin name: ____ Relationship to you: ______________________________

Address: ____ Phone: ______________________

Emergency Contact Name (if different to NOK) : ______________________________ Relationship to you: _____________________

Address: ____ Phone: _______________________

Do you identify with another Cultural Background other than Australian? Yes ☐ No ☐

If so, please nominate your preferred Cultural Background ______________________________________

Are you of Aboriginal or Torres Strait Islander Background? If so, please tick the following: ☐ Aboriginal ☐ Torres Strait Islander

Please fill out the following card details if applicable:

NCACCH Number: __________________________ Reference Number: _____________ Exp date: ___________

THE PRIVACY ACT (2001) We are committed to protecting your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment Act 2012. We are now asking for your consent for the use and disclosure of your health information as required during your health care.

Full Name: _______________________________ Signed: ________________________________

On Behalf of: _____________________________________ Date: _________________________

Your FAMILY history – it is important for us to know of any serious problems that have occurred in your immediate family (father, mother, brother, sister). These include asthma, diabetes, bowel cancer, breast cancer, melanoma, ovary cancer, heart attack, angina, stroke, glaucoma, high blood pressure, depression, panic / anxiety, osteoporosis or any other you may feel important? Comment in box below.

Your medical history. Have you any of the problems listed above or any others. Comment in box below.

Some personal details, please complete in the box below

Do you smoke? Please circle Yes No If so, how many per day?.......... Did you ever smoke? Yes or No

Recreational Drugs Yes No

Do you drink alcohol? Yes No If so how many per day <1 1-2 3-4 5-6

Do you live alone? Yes No If no, do you live with Spouse /partner? Friend? Family?

Do you have children? Yes No If so how many?

Have you had all your childhood vaccines Yes No Don't know?

When was the last time you had a tetanus vaccine ________________ Don't know?

Other Immunisations:

Females: When was your last PAP Smear ___________________________ Mammogram _____________________________

Do you have any allergies? Yes No Please list them below, don't worry about the spelling

Do you take any regular medications? Yes No Please list these below, again don't worry about spelling,