Burnett Medical Centre New Patient Registration Form. Email back: bmc@burnettmedical.com.au

NEW PATIENT REGISTRATION FORM

We want to ensure our records are up to date and accurate. Please check the information on this form and make corrections if needed.

Title Mr ☐ Mrs ☐ Ms ☐ ✓

Surname

First Name

Middle Name

Date of Birth

Residential Address

Postal Address

Home Phone Work Phone

Mobile EMAIL ADDRESS:

Medicare: Ref No: Expiry Date:

DVA Number (Veterans Only) (If White state conditions)

Pension/Health Care Card Number Expiry Date:

Private Health Fund Membership Number

Next of Kin (in case of emergency) Name Phone

Other Emergency Contact. Name Phone

Preferred or first language (if not English)

Please indicate your cultural identity: Aboriginal ☐ Torres St. ☐

Other (please specify):

Would you like to receive text message reminders for appointments that require confirmation? YES ☐ NO ☐

Do you have any allergies to drugs or dressings ? Yes ☐ No ☐ Please write here and tell the doctor

Immunisations :

When was your last injection for Tetanus Whooping cough (approximate year)?

We advise:

- Routine **Tetanus booster** (ADT) now if you have not had one since you were 10. after you are 50 (but not within 10 years of a previous dose).
- One **Whooping cough** (Pertussis) booster especially if in contact with young children.
- **Flu vaccine** annually and 1-2 doses of **Pneumonia vaccine** (Pneumovax) for:
  - everyone from age 65 years
  - patients with lung, heart or other chronic disease at any age pregnant women (Flu vaccine only).
- Aboriginal and Torres Strait people are advised to have further immunisations- please discuss with Doctor or Practice nurse

Are you up to date with immunisations? Yes ☐ No ☐

If you are not up to date with immunisations please check with the nurse or Dr

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Smoking : Do you smoke? *(If you would like help stopping please tell your doctor)*

Yes: ☐ Ex-smoker: ☐ Never Smoked: ☐

Family History - Have parents, brothers or sisters had any of these conditions listed?

Yes ☐ No ☐ (Please tick any that apply)* .

Diabetes:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Heart disease:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Stroke:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Breast Cancer:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Melanoma:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Bowel cancer:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Ovarian cancer:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Aneurysms:	Mother ☐	Father ☐	Sister ☐	Brother ☐
Other serious condition:	Mother	Father	Sister	Brother

Reminder system: Would you like to receive health reminders (e.g. Immunisations, Cholesterol test, Pap smear) Yes ☐ No ☐

Your home, work and other circumstances can affect your health, answering these questions will assist your doctor. Please tick any that apply to you.

How much do you exercise?

Strenuous exercise at least weekly ☐ Walking for 1/2 hour daily ☐ *No regular exercise* ☐

What is your employment/occupation?

Full time ☐ Part time ☐ Domestic duties ☐ Retired ☐ *Disability pension* ☐ *Not employed* ☐ Student ☐

Are you a carer for someone else? No ☐ *Yes* ☐ Details

Do you have a major disability?

No ☐ *Yes* ☐ Details

Housing- do you live on your own or with others?

With spouse/partner ☐*Single parent with child(ren)* ☐On own ☐With parent(s) ☐Other ☐

Have you experienced a major life event in the past year?

No☐ *Death of family member☐ Divorce/separation☐ House move☐ Job loss ☐*

How much alcohol do you drink?

Nil or occasional ☐ 2 or more glasses per day ☐ 1 bottle or more per day ☐

(Bottle wine = 7 standard drinks. 375ml bottle of full strength beer =1.5 standard drinks. 30ml nip of spirits =1standard drink)

How do you rate your diet/nutrition?

Good ☐ *Vegetarian/Vegan ☐ Overweight ☐Underweight ☐*

Have food allergy ☐ On special diet ☐

Please give your Weight **Kg and Height** **Cm if known.**

FOR FEMALE PATIENTS:

Have you had a Pap Smear YES ☐ NO ☐		
When was your last Pap Smear (2 yearly is current recommendation)	Years	Don't know ☐
Would you like to arrange a Pap Smear with Your Doctor ☐ Practice Nurse ☐		

Signed..... **DOB:** **Date:**

For doctor's use:

OFFICE USE ONLY:

Enter data* and scan. Signed.....Date.....