CARLINGFORD COURT
Medical Centre

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

| **Contact Information** | |
|---|---|
| Title: | ☐Mr ☐Mrs ☐Ms ☐Miss ☐Mast ☐ Other |
| Surname: | |
| First Name: | Preferred Name: |
| Date of Birth: | |
| Street Address: | |
| Postal Address: *(if different to above)* | |
| Mobile Phone: | Home Phone: |
| Contact Via: | ☐SMS ☐Email ☐Mobile ph ☐Home ph ☐Letter |
| Email: | |
| Occupation | |
| Do you consent to SMS? | ☐ Yes ☐ No Eg. "your results are back" |

| **Emergency Contact / Next Of Kin Details** | |
|---|---|
| Name: | Relationship to you: |
| Home Phone: | |
| Mobile Phone: | |

**My Health Record:**

Do you consent to your basic health information being uploaded into your "My Health Record"? This would be done once your record contains relevant information to upload E.g.; Immunisations, Allergies, Current medications, Past History.

☐ Yes ☐ No

**Healthcare Identifiers**

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

**Cultural Identity**

Ethnicity: (Where were you born)_____

*do you require an interpreter service?* ☐ No ☐ Yes

Do you identify as Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

Email to: reception@carlingfordcourtmc.com.au

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## Your Health Information

Do you have any allergies or are you sensitive to drugs or dressings?
☐ No
☐ Yes – provide details
***including what is that you are allergic to and also your reaction mild, moderate, severe, Anaphylaxis, Rash, vomiting, Chest Pain, Diarrhoea.*

……

**MEDICAL HISTORY** - Do you have or have you had a history of the following?
☐ Surgery – provide details:
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Heart Disease
☐ Osteoporosis
☐ Other – provide details:

_____

**ALCOHOL CONSUMPTION-**
**Current alcohol intake:**
☐ Non drinker
Days Per Week_____ Standard drinks per day:_____
**Past alcohol intake:**
☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy
Year Started _____ Year Stopped _____

**CURRENT SMOKING HISTORY-**
☐Non Smoker
☐ Ex- Smoker - Year started _____ Year stopped _____
☐ Smoker - Quantity per day _____ Year started _____ Year stopped _____

Signature: Date: **PTO**

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