Kon-Tiki
MEDICAL CENTRE

New Patient Information Sheet

Please fill out ALL content of the form to ensure we can provide the best possible care available.

Title _____ Surname _____Given Names _____

Known as _____ Date of Birth _____/_____/_____ ☐ Male ☐ Female

Place of Birth ☐ Australia Or ☐ _____ Other Ethnicity:_____

Are you from Aboriginal or Torres Strait Islander descent? Yes / No or Both

Medicare No: _____ Patient No: 1 2 3 4 5 6 7 8 Expiry Date: _____/_____

Concession Card: ☐ Pension ☐ Health Care Card ☐ Veterans Affairs

Card No: _____**Exp**. _____/_____/_____

Occupation: _____Employer_____

Address: _____

Suburb: _____State:_____ Postcode: _____

Phone: (Home) _____(Work) _____ (Mobile) _____ Email:

(we may use this to contact you) _____

Emergency Contact (if same address, please write 'as above') *please write clearly*

Name: _____ Relationship to you: _____

Address: _____ Suburb & Post Code_____ _____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Next of Kin (if same address, please write 'as above') *please write clearly*

Name: _____ Relationship to you: _____

Address _____ Suburb & Post Code_____ _____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Before you Register Do you consent to:

***If no please note if you circle NO you are responsible for booking follow up appointments for your results.**

1. Our practice provides our patients with preventative care and early case detection reminders e.g. Immunization, annual health check, Skin checks, pap smears etc. Do you **CONSENT** to being contacted with reminders? **YES/NO (please circle)**
2. Do you consent to being contacted as part of our recall system for the follow up of Investigation results? **YES/NO (please circle)**
3. Do you **CONSENT** to be contacted/ reminded of appointments via SMS? Y**ES/NO (please circle)**
4. Our policy on health information collection and use and general research consent (Please ask reception for copies of this consent forms if you require more info) **YES/NO (please circle)**
5. Our now show/ late cancellation Policy (For more information please advise reception) **YES/NO (please circle)**

Signature: _____ Name: _____ Date: _____

NEW PATIENT MEDICAL INFORMATION SHEET

FULL NAME		
		DATE OF BIRTH

Allergies? (including drugs and dressings)

What illness or operations have you had in the past?

FAMILY HISTORY (Have any of your parents, brothers or sisters had the following)

☐ Melanoma	☐ Diabetes	☐ Heart Attack	☐ Stroke	☐ Bowel Cancer
☐ Hypertension	☐ Depression	☐ Migraine	☐ Asthma	☐ Breast Cancer
☐ Prostate Cancer	☐ Other Information:	☐ Genetic disorder		

Women Only	Number of Births	Dates	Any Complications

Have you ever had a Pap Smear test? ☐ No ☐ Yes Date of last smear? _____ / _____ / _____

Are you on a contraceptive pill? ☐No ☐ Yes Name of Pill? _____

Have you had a Mammogram? ☐ No ☐ Yes Date of last Mammogram? _____/ _____ / _____

CURRENT MEDICAL PROBLEM (What is the reason for today's visit?)

PAST MEDICAL HISTORY (What long term problem do you have ……e.g. Heart disease, diabetes, cancer, operations etc)

MEDICATIONS (Please state what tablets or medicines you take)

Name	Dose	Reason

SOCIAL

Smoking	□ Non Smoker	□ Ex-Smoker	□ Smoker	Amount _____
Alcohol	□ Non Drinker	□ Social Drinker	□ Moderate Drinker	□ Heavy Drinker
Exercise	□ Nil	□ Regular Exercise	□ Moderate Exercise	□ Elite Athlete

IMMUNISATIONS

Are Childhood Immunisations up to date? ☐ No ☐ Yes

Do you have a yearly flu injection? ☐ No ☐ Yes

Date of your last Tetanus Injection? _____ / _____ / _____

Date of your last Pneumonia Injection? (over 65 yrs) _____ / _____

Signature: _____ Name: _____ Date: _____