COLLEGES CROSSING
Family Practice

New Female Patient Information Form

Thank you for taking the time to complete the following paperwork because it will help us provide the best possible care for you and your family.

Mrs/Miss/Ms/Dr/Prof/Rev:
First and last name:
Preferred name:

Date of birth:

Street address: **Suburb and post code:**

Best contact phone (ideally mobile): **Second contact phone:**

Email:

Medicare number: Ref:
Medicare card expiry date:

Healthcare card (if applicable): Expiry date:

Private Health cover, name and number (if applicable):

Next of Kin name: **Next of Kin contact no:**
Other family member names:

Most patients find **SMS reminders and recalls** helpful, if we need to contact you, would you like to be contacted by SMS? Please advise: yes/no

Are you currently **employed**? Please provide details:
If you are **retired**, what kind of work did you do in the past?

Knowing our patient's **backgrounds** help us to provide appropriate care for wide variety of people from different nationalities and ethnicities. Please circle/fill out the following:

Australian
Not aboriginal or Torres Strait Islander
Aboriginal
Torres Strait islander
Aboriginal and Torres Strait Islander

Other ethnicity:

Medical History

***Most importantly* - please list all allergies and reactions, especially to medications:**

If no **allergies** please circle: No known drug allergies

Are you protected against illness by being **vaccinated**?
Are you concerned that vaccinations may not be up to date?

Please list any current or past **medical conditions or surgeries** including mental illnesses:

Please advise of **current medications** (including over the counter medications, vitamins and supplements):

Please list **pregnancies/childbirth**, vaginal/caesar and any complications:

Do you have **trouble with your periods**?

When was your last **pap smear**?
Are you on any **birth control** at present?

Is there a **family history** of any medical conditions? Please note them here:

Have you ever smoked **cigarettes**? When and roughly how many per day?
Do you drink **alcohol**? How many drinks per day on average?

Current weight: **Current height:**

How often do you use the following to protect yourself from the sun when outdoors?

Protective clothing: **Sunscreen:**

What sort of **hobbies or exercise** do you like?

Can you think of any **further information** that may be helpful for your doctor to know?

Thank you for your assistance. Please bring this form in to the consult with your doctor.