COLLEGES CROSSING
Family Practice

New Patient Information Collection 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.

Preferred pronoun (e.g. Ms/Mr):
First and last name (as on Medicare card):
Preferred name:

Birth sex:
Gender:
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:

Next of Kin name: **Next of Kin contact no:**
How is your next of kin **connected** to you?
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**? What work do you do?
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 illness:

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

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

How many **children** do you have?
How many **pregnancies** have you had?
Any **complications** with pregnancy?
Are you using **birth control** at present?

Have you ever smoked **cigarettes**? Roughly when and 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 sport** 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.