North Nowra **Medical Practice**

23 McMahons Rd North Nowra NSW 2541
Telephone: 4423 5991/4421 7366
Facsimile: 4423 4904 After Hours: 4423 3043

PLEASE READ & COMPLETE ALL PAGES

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐

Surname ______________________________

First Name ______________________________

Middle Name____________________________

Preferred Name __________________________

Date of Birth ____ / ___ /______

Male ☐ Female ☐

Ethnicity
- ☐ Aboriginal Australian
- ☐ Torres Strait Islander
- ☐ Aboriginal & Torres Strait Islander
- ☐ Australian

Other ethnicity___________________________

Home Address ___________________________

____

Suburb ________________________________

Postal Address (if different)

____

____

Contact phone number

Landline (H) ☐☐ ☐☐☐☐☐☐☐☐

Mobile ☐☐☐☐ ☐☐☐ ☐☐☐

Work: ☐☐ ☐☐☐☐☐☐☐☐

Email Address: __________________________

Do you agree to SMS appointment reminders ?

Yes ☐ No ☐

Have your ever had a Care Plan (CDM) ?______

Medicare Number/Vet Affairs-Gold Card No:

☐☐☐☐☐☐☐☐☐☐

Ref number (next to your name) ☐

Medicare expiry date ☐☐ - ☐☐☐☐

Do you have a Pensioner Concession Card?

No ☐ Yes Card no: ☐☐☐☐☐☐☐☐☐☐

Card Expiry Date ☐☐ / ☐☐ /☐☐☐☐

Do you have a Health Care Card? No ☐ Yes ☐

Card no: ☐☐☐☐☐☐☐☐☐☐

Card Expiry Date ☐☐ / ☐☐ /☐☐☐☐

____

Religion_______________________________

Next of Kin ____________________________

Relationship_____________________________

Phone ________________________________

2nd Emergency Contact (IF different to NOK)

Name _________________________________

Relationship ____________________________

Phone ________________________________

Your occupation *or if retired previous occupation*, of person who this form is for

____

ALLERGIES
- NO
- YES (please list)

____

SOCIAL HISTORY

- Single ▪ Married ▪ Defacto ▪ Separated ▪ Divorced
- Homosexual(gay) ▪ Heterosexual(straight) ▪ Bisexual (both)

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Do you have any of the following diseases / conditions?

ANXIETY ▪ Yes ▪ No

ARTHRITIS ▪ Yes ▪ No

ASTHMA ▪ Yes ▪ No

CANCER(type?) ________________ ▪ Yes ▪ No

DEMENTIA/ ALZHEIMERS ▪ Yes ▪ No

DEPRESSION ▪ Yes ▪ No

DIABETES ▪ **No** ▪ **Yes** ▪ Type 1 ▪ Type 2

EMPHYSEMA ▪ Yes ▪ No

GALL BLADDER INFECTION ▪ Yes ▪ No

HEART CONDITION ▪ Yes ▪ No

HEPATITIS ▪ Yes ▪ No

HIGH BLOOD PRESSURE ▪ Yes ▪ No

LOW BLOOD PRESSURE ▪ Yes ▪ No

KIDNEY DISEASE ▪ Yes ▪ No

OSTEOPOROSIS ▪ Yes ▪ No

PARKINSON'S DISEASE ▪ Yes ▪ No

STROKE ▪ Yes ▪ No

THYROID DISEASE ▪ Yes ▪ No
Taking thyroid medication ▪ Yes ▪ No

OTHER (including broken bones): Please list
____
____
____

OPERATIONS
____
____
____

SMOKING STATUS ▪ Non smoker
▪ Ex smoker Quit date: __________
▪ Smoker
Smokes per day:________ Year started:__________
Wanting to quit? ▪ Yes ▪ No ▪ Thinking about it

ALCOHOL INTAKE ▪ Non drinker
Days per week: _______ ▪ Less than monthly
How many standard drinks per day? __________________

PHYSICAL ACTIVITY
Are you an elite athlete? ▪ Yes ▪ No
Adults: least 30 mins exercise most days? ▪ Yes ▪ No
Child: watching more than 1 hour TV/ computer most days?
▪ Yes ▪ No

Do you have a carer? ▪ Yes ▪ No
Are you a carer? ▪ Yes ▪ No

FAMILY HISTORY
Mother alive? ▪ Yes ▪ No **Age at death**:________
Cause: ____________________________________
Father alive? ▪ Yes ▪ No **Age at death**:_______
Cause: ____________________________________

Does anyone in your family have or has had: - includes grandparents, father, mother, siblings, aunts & uncles (please indicate)

ASTHMA
▪ No ▪ Yes ______________________________

BOWEL CANCER
▪ No ▪ Yes ______________________________

BREAST CANCER
▪ No ▪ Yes ______________________________

DIABETES
▪ No ▪ Yes ______________________________

DEPRESSION
▪ No ▪ Yes ______________________________

HEART DISEASE / HEART ATTACK
▪ No ▪ Yes ______________________________

HIGH BLOOD PRESSURE
▪ No ▪ Yes ______________________________

STROKE
▪ No ▪ Yes
____

FOR WOMEN
Date of last pap smear: __________

I believe the above to be a true account of my health information.

Signature:________________________________

Name:___________________________________

Relationship: ▪ Self ▪ Parent/Carer ▪ Translator