Fitzroy North Medical Clinic

New Patient Registration Form

Please Circle Title: Mr. Mrs. Ms. Miss. Mast. Gender: M / F / Other

First Name: _____ Family Name: _____

Date of Birth: ___/___/____ Preferred Name: _____Occupation: _____

Address: _____

Suburb: _____ Postcode: _____

Postal Address (if different to above): _____

Suburb: _____ Postcode: _____

Mobile: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Please Circle: Are you an Aboriginal, Torres Strait Islander or both? Yes / No

Cultural Background/ Ethnicity: _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ __ Reference Number: _____

Expiry Date: _____/_____/_____ Marital Status: _____

Please Circle: Pension / Health Care Card Number:

_____ Expiry: _____

DVA Card Veteran Affairs **Please circle:** Gold / White

_____ Expiry: _____

Next of Kin Name: _____ Relationship: _____

Contact Number: _____

Emergency Contact Name: _____ Relationship: _____

Contact Number: _____

Do you consent to SMS or other relevant medical reminders? Yes / No

In signing your patient registration, you are consenting to be seen by a GP of the practice and receiving appointment reminders and other relevant medical reminders by SMS

How did you find out about us? E.g.) Instagram, Internet, Pamphlet or Family _____

Signed: _____ Date: _____

Fitzroy North Medical Clinic

Patient Health Summary

First Name: _____ Last Name: _____

Date of Birth: _____/_____/_____

Current Medical History

Do you have any Allergies? *Please Circle:* YES / NO / UNKNOWN

If '*Yes*' Please list down known allergies you may have.

_____

Are you currently taking any medications?

Please Circle: YES / NO

If '*Yes*' Please list down current medication.

_____

_____

Are you currently using any complementary or alternative medicines or therapies?

Please Circle: YES / NO

If '*Yes*' Please list down current medications or therapies.

_____

_____

Past Medical History

Do you smoke? YES / NO **Do You Drink Alcohol?** YES / NO

If '*no*' have you ever smoked? YES / NO **Frequency** _____

If '*yes*' how long ago did you quit? _____ **Have you tried Quitting** YES / NO

Have you ever had or have any of the conditions below? If '*Yes*' Please Circle.

Diabetes Kidney Disease Asthma Bowel Cancer Breast Cancer

High Blood Pressure Heart Problems Epilepsy Depression/Anxiety

Other mental health

Other: _____

Is there a Family History of any of these conditions? If 'Yes' Please Circle.

Diabetes Kidney Disease Asthma Bowel Cancer Breast Cancer

High Blood Pressure Heart Problems Epilepsy

Other: _____

If 'Yes' state relationship to you _____