

NEW PATIENT REGISTRATION FORM

Please show the receptionist your Medicare card and any Centrelink and/or Veterans Affairs gold cards

Title:	Name:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Surname:		Preferred Name:	
Date of Birth:	Marital Status:	Country of Birth:	
		Cultural Belonging:	
Are you Aboriginal or Torres Strait Islander?		Aboriginal <input type="checkbox"/>	Torres Strait Islander <input type="checkbox"/> No <input type="checkbox"/>
Street Address:			
Postal Address (if different to above):			
Home:	Mobile:	Work:	
Email:			
Occupation:			

Do you consent to SMS appointment reminders, result notification and correspondence? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Health alert emails may be sent to you periodically - you may unsubscribe if you wish.</i>			
Would you like to register for E-Health? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How did you hear about Pioneer Health? <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Billboard <input type="checkbox"/> Other			

Next of Kin		
Name:	DOB:	Relationship:
Home phone:	Mobile:	

Emergency Contact Details (if different to above)		
Name:	DOB:	Relationship:
Home phone:	Mobile:	

Consent

I consent to the disclosure and/or use of my personal health information by Pioneer Health and other health providers directly or indirectly involved in my personal health care or medical treatment.

Signed: _____

Date: _____

A copy of our Personal Health Information (Privacy) Policy is available on request.

Your personal information is kept private and secure, as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with GP.

MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Medical history (please tick)	Family history (please tick and list family members)
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> GORD	<input type="checkbox"/> Asthma <input type="checkbox"/> Back Pain <input type="checkbox"/> Mental Health <input type="checkbox"/> Seizures/Blackouts/Epilepsy <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Gynaecology Problems <input type="checkbox"/> Sleep Apnoea <input type="checkbox"/> Auto Immune Disease <input type="checkbox"/> Behavioural Issues <input type="checkbox"/> Other
	<input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Cancer _____ Type (if known) _____

Please list any medications (including vitamins)	Allergies										
_____ _____ _____ _____ _____	<table border="1"> <thead> <tr> <th>Allergy</th> <th>Reaction</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table> <input type="checkbox"/> No known allergies	Allergy	Reaction	_____	_____	_____	_____	_____	_____	_____	_____
Allergy	Reaction										
_____	_____										
_____	_____										
_____	_____										
_____	_____										

Smoking history	Alcohol												
<input type="checkbox"/> Never <input type="checkbox"/> Former smoker – quit date _____ <input type="checkbox"/> Current smoker _____ per day	<table border="1"> <tbody> <tr> <td>How often do you have a drink of alcohol?</td> <td> <input type="checkbox"/> Never <input type="checkbox"/> 2-3 times a week </td> <td> <input type="checkbox"/> Monthly or less <input type="checkbox"/> 4 or more a week </td> <td> <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 5 or 6 </td> </tr> <tr> <td>How many standard drinks containing alcohol do you have on a typical day?</td> <td> <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 7 to 9 </td> <td> <input type="checkbox"/> 3 or 4 <input type="checkbox"/> 10 or more </td> <td></td> </tr> <tr> <td>How often do you have six or more drinks on one occasion?</td> <td> <input type="checkbox"/> Never <input type="checkbox"/> Weekly </td> <td> <input type="checkbox"/> Less than monthly <input type="checkbox"/> Daily or almost daily </td> <td> <input type="checkbox"/> Monthly </td> </tr> </tbody> </table>	How often do you have a drink of alcohol?	<input type="checkbox"/> Never <input type="checkbox"/> 2-3 times a week	<input type="checkbox"/> Monthly or less <input type="checkbox"/> 4 or more a week	<input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 5 or 6	How many standard drinks containing alcohol do you have on a typical day?	<input type="checkbox"/> 1 or 2 <input type="checkbox"/> 7 to 9	<input type="checkbox"/> 3 or 4 <input type="checkbox"/> 10 or more		How often do you have six or more drinks on one occasion?	<input type="checkbox"/> Never <input type="checkbox"/> Weekly	<input type="checkbox"/> Less than monthly <input type="checkbox"/> Daily or almost daily	<input type="checkbox"/> Monthly
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Immunisations (please tick which vaccines are up to date)
<input type="checkbox"/> Pneumococcal (pneumonia) - Date received: _____ <input type="checkbox"/> Tetanus - Date received: _____ <input type="checkbox"/> Other (please specify) _____ Date received: _____
<input type="checkbox"/> Influenza - Date received: _____ <input type="checkbox"/> Childhood vaccines - Date received: _____

Gender related health history (specify approx month/year)
Last pap smear _____ Last mammogram (if aged over 50) _____ Last prostate check (if aged over 40) _____

Signed: _____ **Date:** _____

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