LAURIMAR MEDICAL

120 Painted Hills Road,
Doreen VIC 3754
Tel: 9717 0804
Fax: 9717 0806

NEW PATIENT FORM **Once completed, please hand this page of the questionnaire to the reception.**

For your first appointment, please attend the practice 20 minutes before your appointment time. This allows your registration to be completed in time for you to see the Doctor.

Title	Name	Surname

Date of birth:	□ Male □ Female	MEDICARE NO: REF: EXPIRY:

Do you have a □ **Health Care Card**

□ **DVA card** □ **Pension Card**

Card no.	Expiry date:

ETHNICITY: □ **Aboriginal** □ **Torres Strait Islander** □ **Aboriginal and Torres Strait Islander** □ **NON ATSI**

Home address	Work address
Postcode	Postcode

Phone: (H)	Phone: (W)	Phone: (M)
EMAIL:		

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Separated** □ **Widowed** □ **Defacto**

Country of Birth	Citizenship

Emergency contact details:

Name	Relationship: Address:	Phone: (H) Phone: (W) Phone: (M)

PATIENT PRIVACY Information: To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but also from family members and other health care providers. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor. We will be offering a service to contact you via sms regarding your recall appointments.

I give permission for **LAURIMAR MEDICAL** to contact me via SMS □ Yes □ No
email □ Yes □ No

I give permission Mernda Village Medical & Dental for to release my records to Laurimar Medical AND vice versa ☐

Patient / Guardian Signature _____

Date _____

Seen by **doctor** _____
Scanned □

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Once completed, please hand this section of the questionnaire directly to you Doctor.

Patient name:_____Date of Birth:_____

What medical concerns do you wish to discuss with your doctor today?

_____

Past Medical History Have you suffered from any of the following – currently or previously?

□ Heart problems	□ Stroke	□ High blood pressure	□ Blood clots	□ Glaucoma
□ Epilepsy	□ Anxiety / depression	□ Asthma	□ Bronchitis	□ Diabetes
□ Back Pain	□ Eye problems	□ Thyroid problems	□ Hep C	□ Hep B
□ Liver disease	□ Kidney disease	□ Osteoporosis	□ Fractures	□ Arthritis
□ Hearing loss	□ Migraines	□ Skin conditions	□ Cancer	□ High Cholesterol
□ HIV	□ Any other _____			

Preventative health: Please tick the boxes where appropriate

ALL	FEMALES	MALES	Any illnesses, operations or hospital admissions
Bowel screening □ Date:	Pap smear □ Date:	Prostate check □ Date:	
Skin Check □ Date:	Mammogram □ Date:	Testis check □ Date:	
Unintended weight change □ _____KG since (date) _____	Health check □ Date:	Health check □ Date:	
	Immunisations:	Immunisations:	

MEDICATIONS AND SOCIAL HISTORY:
Please include ALL tablets, inhalers, patches, gels or injections – as well as any other "natural" remedies or supplements.

MEDICATION	DOSE	FREQUENCY	
			SMOKER □ _____per day NON SMOKER □ **EX-SMOKER □ QUIT IN _____**
			ALCOHOL _____days per week_____drinks per day
			Non-drinker □
			Recreational drugs □ Specify_____
			Married □ Single □ Divorced □ De-facto □
			Occupation:

FAMILY HISTORY	MOTHER Alive □	FATHER Alive □	SIBLINGS
Heart attack	□	□	□
Bowel cancer	□	□	□
Breast cancer	□	□	□
High blood pressure	□	□	□
Stroke	□	□	□
Arthritis	□	□	□
Blood clot/s	□	□	□
Depression	□	□	□
Diabetes	□	□	□
Thyroid disease	□	□	□
Haemachromatosis	□	□	□
Osteoporosis	□	□	□
Other:			

ALLERGIES

_____
_____
_____
_____
_____
_____

Any other concerns at all? _____

The information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge.

Patient / Guardian Signature _____

Name: _____ Surname: _____Date _____