McLeod Street
MEDICAL

67 McLeod Street
Cairns 4870
Ph: 07 4052 1583
Fax: 07 4052 1930

This information is private and confidential and is for use in your clinical file only

NEW PATIENT DETAILS - Please print and give as much detail as possible to assist us to provide quality care.

Title: Mr / Mrs / Ms / Miss / Mast / Dr (please circle) **Gender:** Male / Female (please circle)

Marital Status: Single Married De-facto Divorced Widowed Separated

Surname: _____ **First Name**: _____

Middle Name: _____ **Preferred Name**: _____

Residential Address: _____

Postal Address: (if different to home) _____

Town/Suburb: _____ **Postcode:** _____

Date of Birth _____/_____/_____

Home Phone: _____ **Mobile:** _____

Work Phone: _____ **Do you consent to SMS reminders: Yes / No**

Email Address: _____

Ethnicity: Australian / Aboriginal / TSI / ATSI / PNG / Japanese / Other _____

Occupation: _____ Employed / Self Employed / Unemployed / Retired / Student

Medicare Number: _____ **Expiry Date:** _____/____ **Ref no** _____ (next to name)

Vet Affairs No._____ **Expiry Date:**_____

Pension/Healthcare Card Number._____ **Expiry Date:**_____

Do you have private health care fund? Yes / No

Which Fund _____ **Fund Number** _____

Next of Kin: _____ **Relationship:** _____

Contact Number: _____

Emergency Contact: _____ **Relationship:** _____

Contact Number: (If different from Next of Kin) _____

How did you hear of McLeod Street Medical _____

As part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due.

I consent / do not consent to receive follow up reminders and recalls to be sent to the above address.(please circle)

Signature _____ DATE ----/-----/------

Patient Health Information (Patient to complete)

Current Medications and Doses including Vitamins and herbal medicine:

_____
_____
_____

Please list any known allergies and your reactions e.g. Drugs/ Dressings or list nil known if none:

_____
_____

Please list any operations or previous illnesses:

_____
_____

Immunisations: Tetanus: Yes / No/Unknown Date: _____ Hepatitis A & B: Yes / No/Unknown Date: _____

Influenza: Yes/No/Unknown Date: _____ Polio: Yes / No/Unknown Date: _____

Children's Immunisations – Are they up to date? Yes / No / Unknown

SOCIAL HISTORY: Please circle the most appropriate answer

Marital Status: Single Married De-facto Divorced Widowed Separated

Recreational Activities: _____

Does the patient have a Carer: Yes / No **Carer's Name:** _____

Address: _____ **Contact Number:** _____

Alcohol Consumption: Do you drink alcohol? Yes / No

If yes how many? Daily ____ Weekly ____ Occasionally ____ Socially ____ Never ____

Smoking: Do you smoke? Yes / No / Never If yes how many per day? _____

Date Ceased: _____

Occupation: _____ Employed / Self Employed / Unemployed / Retired / Student

MEDICAL HISTORY: Please circle the most appropriate answer fill out all other areas

Have you ever had: Diabetes Kidney Disease Asthma High Blood Pressure
Heart Problems Breast Cancer Colon Cancer Stroke
Depression Epilepsy Other Cancer _____

Women's Health: Date of latest Pap Smear _____ Breast Check/Mammogram _____

Family History: Unknown (eg Adopted) No significant family history Other – see list below
Kidney Disease Asthma High Blood Pressure Diabetes
Heart Problems Breast Cancer Colon Cancer Stroke
Depression Epilepsy Other Cancer _____

Other immediate family member's significant illness: _____
_____

Do you know your blood group? Yes / No **Blood Group:** _____

If this information is for your child please provide a copy of your child's immunisation history to the nurse.
At McLeod Street Medical we strive to provide high quality care, appropriate to meet our clients health care requirements.
By becoming a patient of McLeod Street Medical and signing this new patient form I agree and consent to the following:
I consent to the use of my personal health information by the McLeod Street Medical Team and other health care providers involved in my medical treatment and health care within this centre.
I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.

Signature: _____ **Date:** _____/_____/_____

Printed Name: _____