New Patient Information Sheet

Full Name: ..... **DOB:** .....

Address:…… **Tel No:**……

…… **2nd Contact**:……..

Occupation: .....**Next of Kin**……

Please indicate if you identify yourself as an indigenous Australian of either Aboriginal or Torres Strait Islander cultural descent ❑

Past Medical History
Please tick if you have any of the following conditions

☐ Diabetes	☐ Cancer	☐ Respiratory Diseases
☐ Asthma	☐ High blood pressure	☐ Epilepsy
☐ Heart Conditions	☐ High Cholesterol	☐ Mental Health Issues

Other: .....

Social History

☐ Live with partner ☐ Live alone

Number of children: ..... ☐ Children live at home ☐ Offspring live elsewhere

Other: .....

Family Medical History

Father: .....

Mother: .....

Siblings/Children: .....

Allergies include reaction

.....

.....

Smoking History

☐ Smoker Number per day: …… Year commenced: ……..

☐ Ex-smoker Quit date: ……..

☐ Never smoked

Alcohol history

Number of days per week usually drink alcohol .....

Number of standard drinks per day .....

Please fill in Medications on the reverse side of page

Medications

.....

.....

.....

.....

.....

.....

.....

.....

.....

Other Information

.....

.....

.....

.....

.....

.....

.....

.....