myhealth
MEDICAL CENTRE

Title: Mr / Mrs / Ms / Miss / Mast / Dr / Other (please specify) ______________________________

Surname: ________________________ First Name: ____________________________

Preferred Name (if different to above): ____

Date of Birth: _____/_____/________ Gender: male / female

Ethnicity: ________________________ Aboriginal or Torres Strait Islander? yes / no

Marital Status: ____________________ Occupation: ___________________________

Address: ____

Suburb: _________________________ Postcode: _____________________________

Home Phone: _____________________ Work Phone: ___________________________

Mobile: ________________________ Email: _________________________________

Do you have any of the following cards?

Health Care Card / Pension Concession Card / Commonwealth Seniors Health Card / DVA (please specify)

Card Number: ____________________________________ **Expiry**: _____/_____/_____

DVA Number: ____________________________________ white / gold / lilac / orange

Next of Kin contact: ____

Contact Number: _________________________ Relationship: _____________________

Emergency contact: ____

Contact Number: _________________________ Relationship: _____________________

How did you hear about us?

☐Facebook ☐Google Search ☐Internet ☐Word of Mouth

☐Walk-By ☐Signage ☐Flyer ☐Other: __________________

I AGREE TO ALLOW MYHEALTH MEDICAL CENTRE TO COLLECT INFORMATION RELEVANT TO MEDICAL CARE AND TREATMENT FROM THE DOCTORS.
I CONSENT TO THE USE OF MY MOBILE NUMBER FOR SMS OR EMAIL TO CONTACT ME FOR REMINDERS, RECALLS, HEALTH ALERTS AND/OR HEALTH NEWSLETERS. (Please refer to our SMS policy at reception).

Patient Signature: ______________________________ Date: ______________________

PLEASE FILL IN THIS SECTION AND GIVE TO YOUR DOCTOR

Medications ____________________________ Allergies ___________________________

Smoking status: non-smoker / ex-smoker / smoker, number per day: __________

Do you drink alcohol? yes / no If yes, days per week? __________ Drinks per day? ____

Family History ____

Pre-existing medical conditions ____

When did you last have an overall check-up? Date ____________ / Unsure / Never

Females, when did you last have a pap smear? Date ____________ / Unsure / Never