



Pear Tree  
Family Practice

## Patient Information Form

Office Use Only: <b>Scanned</b> <input type="checkbox"/>	Mr/Mrs/Ms/Dr/Professor/Mast/Miss	Female/Male/Other
First Name(s)		Surname:
Preferred Name		DOB:
Ethnicity (Please tick)	Australian <input type="checkbox"/> ATSI <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify)	
Address		
Postal Address		
Home Phone		Work Phone:
Mobile Phone		Occupation:
Medicare Number	Person No	Expiry
DVA Number	Gold/White	Expiry
Pension/ Health card no		Expiry
Next of Kin (Name, Number & relationship)		
Emergency Contact (Name, Number & relationship)		
<b>Parents/Guardians of Patients under 16 please fill out your details below</b>		
Head of Family (Name, Number & DOB)		
Medicare Number		

**We use reminder systems for health reviews, pap smears, vaccinations and other relevant issues. Do you consent to being contacted by: (circle all that apply)**

SMS Yes/No                      Phone Yes/No                      Letter Yes/No

Your privacy is very important to us. Do you consent to your health information being shared with other health providers or agencies including national registries for cervical screening, bowel and breast cancer, if required, for your ongoing care? Please tick Yes  No

Our privacy policy outlines the way in which we will collect and use your information. Our privacy policy is available from reception or online.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Please Turn Over

**PAST MEDICAL HISTORY**

Condition/Surgery	Year

**MEDICATIONS**

**IMMUNISATIONS**

	Childhood: Up to date    yes <input type="checkbox"/> no <input type="checkbox"/>
	Influenza:                    yes <input type="checkbox"/> no <input type="checkbox"/>
	Travel:

<p><b>ALLERGIES</b>            Yes    No</p> <p>_____</p> <p><b>SMOKING</b></p> <p>Do you smoke            Yes    No</p> <p>If yes; number each day _____</p> <p>Have you considered quitting?</p> <p style="padding-left: 150px;">Yes    No    Maybe</p> <p>Have you previously quit smoking Yes</p> <p style="padding-left: 40px;">No</p> <p>If yes; which year did you quit? _____</p>	<p><b>ALCOHOL</b>            Yes    No</p> <p>How many days a week do you drink?</p> <p>_____</p> <p>Number of standard drinks on those days?</p> <p>_____</p> <p>How often do you consume more than 6 standard drinks in a day?</p> <p>_____</p>
<p><b>WOMEN'S HEALTH</b></p> <p>Last Cervical Screen (25-74 years)</p> <p>_____</p> <p>Last Mammogram (40-74 years) _____</p> <p>Last Bowel cancer screening (50-75 years)</p> <p>_____</p>	<p><b>MEN'S HEALTH</b></p> <p>Last Prostate check (50-69 years) _____</p> <p>Last Bowel Cancer screening (50-75 years)</p> <p>_____</p>
<p><b>FAMILY HISTORY</b> (eg cancers, diabetes, heart attacks, high blood pressure, asthma, depression)</p>	
<p>Father</p>	<p>Mother</p>
<p>Siblings</p>	<p>Grandparents</p>