Pear Tree Family Practice

Patient Information Form

Office Use Only: **Scanned** ☐	Mr/Mrs/Ms/Dr/Professor/Mast/Miss		Female/Male/Other
First Name(s)		Surname:	
Preferred Name		DOB:	
Ethnicity (Please tick)	Australian ☐ ATSI ☐ Other ☐ (Please Specify)		
Address			
Postal Address			
Email 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)			
Parents/Guardians of Patients <16 please fill out your details below			
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 ☐ no ☐
	Influenza: yes ☐ no ☐
	Travel:

ALLERGIES Yes No _____ **SMOKING** Do you smoke Yes No If yes; number each day _____ Have you considered quitting? Yes No Maybe Have you previously quit smoking Yes No If yes; which year did you quit? _____	**ALCOHOL** Yes No How many days a week do you drink? _____ Number of standard drinks on those days? _____ How often do you consume more than 6 standard drinks in a day? _____
WOMEN'S HEALTH Last Cervical Screen (25-74 years) _____ Last Mammogram (40-74 years) _____ Last Bowel cancer screening (50-75 years) _____	**MEN'S HEALTH** Last Prostate check (50-69 years) _____ Last Bowel Cancer screening (50-75 years) _____

FAMILY HISTORY (eg cancers, diabetes, heart attacks, high blood pressure, asthma, depression)

Father	Mother
Siblings	Grandparents