|  |  |
| --- | --- |
| **Male /Female /Other (Circle one) Title** | 🞏 Dr 🞏 Mr 🞏 Mrs 🞏 Ms 🞏 Miss |
| **Surname** | **First Name** |
| **Occupation** | **Date of Birth** |
| **Street Address** | **Suburb and Post Code** |
| **Mobile Phone :** | **Home Phone:** | **Work Phone:** |
| **Medicare Number & Ref #:****Exp: /** | **Next of Kin** Name:Relationship: | NOK Contact no: |
| **Pension Number** #: Exp: / | 🞏 **DVA Gold** 🞏  **DVA White** (Please tick one)  | #:Exp: /  |
| **HCC Number** #: Exp: / | **Private Health Cover:** | **#:** |
| **To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?** |
| 🞏 No 🞏 Yes – Aboriginal & Torres Strait Islander 🞏 Yes – Aboriginal 🞏 Yes - Torres Strait Islander |
| Do you smoke?  | 🞏 No 🞏 Yes Number \_\_\_\_ day / \_\_\_\_ week **Have you tried to stop smoking? Yes / No Longest time without smoking: \_\_\_\_\_\_\_\_\_\_**🞏 Ceased smoking Date: No of years smoking: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you drink Alcohol? | 🞏 No 🞏 Yes Number \_\_\_\_ day / \_\_\_\_ week / \_\_\_\_ month **Are you concerned about your drinking? Yes / no** |
| Drug Use? | 🞏 No 🞏 Yes. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Your Health History - Do you have or have you had a history of the following?** (please elaborate) |
| 🞏 Asthma 🞏 Diabetes 🞏 Hypertension 🞏 Heart disease 🞏 Breast Cancer 🞏 Bowel Cancer 🞏 Other |
| 🞏 Chronic Illness: 🞏 Operations/procedures:**FAMILY HISTORY of any of the above? (Please list condition and relationship):****Current Medications (Please list any changes):** |
| **Measurements:** Height \_\_\_\_\_\_\_\_\_ cm Weight: \_\_\_\_\_\_ kg  |
| **Do you have any ALLERGIES or are you sensitive to drugs or dressings?** 🞏 No 🞏 Yes. Please elaborate: |
| **Any recent vaccinations?** 🞏 No 🞏 Yes **If yes, please list**: |

**Do you consent to uploading your MyHealth Record (PCEHR)?** 🞏Yes 🞏 No