New patient questionnaire

Warrandyte Road Clinic

Personal details

Surname _____ Title _____

Given Name _____ Gender ☐ Male ☐ Female

Address _____

Home phone _____ Work phone _____

Mobile phone _____ Date of birth _____

Medicare no. _____ Exp: / Occupation _____

Pension card _____ Exp: / Health care card _____ Exp: /

Aboriginal / Torres Strait Islander origin? ☐ Yes ☐ No Email address _____

Do you have any ethnic or cultural background we should be aware of? _____

Emergency contact

Name _____

Phone _____

Relationship to you _____

Previous GP details

GP's name _____

Clinic address _____

Clinic phone _____

Past medical conditions

Current medications

Allergies

Do any medical conditions run in your family?

Please turn over ➔

Vaccinations

Have you received:		Year received
Flu vaccine	Yes / No	_____
Pneumonia vaccine	Yes / No	_____
Tetanus vaccine	Yes / No	_____

Other information

Are you a smoker?	Yes / No	If Yes, how many cigarettes per day?	_____
Ex-smoker?	Yes / No	If Yes, what year did you quit?	_____
Alcohol?	Yes / No	If Yes, how many drinks in an average week?	_____

How did you hear about us?

- ☐ Friend or family
- ☐ Yellow Pages
- ☐ Google search
- ☐ Walked or drove past
- ☐ Another health professional: _____
- ☐ Other: _____

Privacy agreement

Your medical records are confidential. It is our policy that only authorized staff have access to your personal information. Our privacy policy is available on our website or you may ask our staff for a copy.

Signature _____ Date _____