Kincraig
Medical Clinic

Patient Information Form

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:

Title: (please circle)	Mr	Mrs	Ms	Miss	Dr
Surname:			First Name:	
Date of Birth:			Home Phone:	
Mobile Phone:			Work Phone:	
Email:				
Street Address:			State:	
Suburb:			Post Code:	
Medicare Number:			Expiry Date:	
DVA Gold / White (please circle)			Expiry Date:	
Pension Number:			Expiry Date:	
Health Care Card Number:			Expiry Date:	
Next of Kin:			Contact Number(s):	
Emergency Contact:			Contact Number(s):	

If we need to contact you, what is your preferred method of contact?

☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Mail

Do you have any health concerns that you would like to receive more information on?

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes – Please Elaborate _____
☐ No

To assist with health initiatives, are you Aboriginal or Torres Strait Islander?

☐ Yes – Aboriginal
☐ Yes – Torres Strait Islander
☐ Yes – Aboriginal & Torres Strait Islander
☐ No

Family History – have any members of your family had:

☐ Diabetes
☐ Asthma
☐ Heart Disease
☐ Mental Illness
☐ Cancer

Social History

☐ Tobacco: _____ day / week (please circle) or Cease Smoking – date _____
☐ Alcohol: _____ day / week / month (please circle)
☐ Drug use: _____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs

Blood Pressure: When was the last time your blood pressure was taken?

_____

For those 65 years and older: When was the last time you were immunised?

Influenza:	Date _____	☐ Not Sure	☐ Never
Pneumococcal pneumonia:	Date _____	☐ Not Sure	☐ Never

Females: When did you last have?

Pap smear:	Date _____	☐ Not Sure	☐ Never
Breast Check:	Date _____	☐ Not Sure	☐ Never

Males: When did you last have?

An overall check up:	Date _____	☐ Not Sure	☐ Never

Your Health History: Do you have or have you had a history of?

- ☐ Operations _____
- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Hypertension _____
- ☐ Chronic Illness _____
- ☐ Other _____

Do you have any allergies or are you sensitive to drugs or dressings?

☐ Yes (please list below) ☐ No

_____

_____

Immunisations: Have you had the following immunisations?

Tetanus booster:	Date _____	☐ Don't Know	☐ Haven't had one
Hepatitis B:	Date _____	☐ Don't Know	☐ Haven't had one
Hepatitis A:	Date _____	☐ Don't Know	☐ Haven't had one
Influenza:	Date _____	☐ Don't Know	☐ Haven't had one
Pneumococcal:	Date _____	☐ Don't Know	☐ Haven't had one
Polio:	Date _____	☐ Don't Know	☐ Haven't had one

Children's Immunisations: If completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No

Current Medications (including over the counter medications, vitamins and minerals):

_____

_____

_____

_____

_____

Patient Signature: ……..... Date _____
(or parent &/or guardian)