Homeworld Helensvale Medical Centre
where good health matters

Welcome to our practice. For information regarding our services and opening hours please ask our reception staff for the practice information booklet.

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate. This information is kept strictly confidential.

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Given Names Surname

Known As Date of Birth / / Sex M ☐ F ☐

Do you identify as being ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

☐ Aboriginal & Torres Strait Islander

Medicare Number Patient # Expiry Date /

DVA Number Expiry Date / ☐ Gold Card ☐ White Card

Pension / Health Care Card Number Expiry Date / /

Private Health Cover ☐ Basic ☐ Intermediate ☐ Top Fund Name

Street Address

Suburb & Post Code

Postal Address

Suburb & Post Code

Home Phone Work Phone Mobile

Email

Marital Status ☐ Single ☐ Married ☐ De Facto ☐ Separated ☐ Divorced ☐ Widowed Year of Arrival

Occupation Country of Birth

Next of Kin

Name Date of Birth / /

Address

Suburb & Post Code

Home Phone Work Phone Mobile

Relationship to you

Emergency Contact ☐ Same as Next of Kin

Name Date of Birth / /

Address

Suburb & Post Code

Home Phone Work Phone Mobile

Relationship to you

Do you identify as from a culturally diverse and/or non-English speaking background?

☐ China ☐ Greece ☐ India ☐ Iraq ☐ Italy ☐ Sri Lanka ☐ Sudan ☐ New Zealand ☐ Russia ☐ Philippines

☐ Thailand ☐ Korea ☐ Malaysia ☐ Vietnam ☐ Other religious, cultural

Ethnicity

Previous GP Name & Address

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Patient Medical/Health History

Name _____ **Date of Birth** _____

Reminder System:
Our practice provides our patients with preventive care and early case detection reminders, eg. immunusations, annual health checks, skin checks and pap smears. We routinely send health reminders.

Please check the box if you do **NOT** wish to have these reminders sent to you ☐

If we need to contact you what is your preferred method of contact: ☐ Phone ☐ Mail ☐ Email

Do you have any allergies or are you sensitive to drugs or dressings ☐ Yes (if yes please list below) ☐ No

Family History – Have any members of your family had?

☐ Diabetes _____

☐ Asthma _____

☐ Heart Disease _____

☐ Mental Illness _____

☐ Cancer _____

Social History

☐ Tobacco _____ day /week or Ceased Smoking – Date _____

☐ Alcohol _____ day /week /month (circle the one applicable)

☐ Drug use _____
(Type and Frequency)

Do you have or had a history of?

☐ Operations _____

☐ Asthma _____

☐ Diabetes _____

☐ Hypertension _____

☐ Chronic Illness _____

☐ Other _____

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Patient Medical/Health History

Immunisation – Have you had the following immunisation?

Tetanus Booster	☐ Yes – Date _____	☐ No	☐ Unsure
Hepatitis B	☐ Yes – Date _____	☐ No	☐ Unsure
Hepatitis A	☐ Yes – Date _____	☐ No	☐ Unsure
Influenza	☐ Yes – Date _____	☐ No	☐ Unsure
Pneumococcal	☐ Yes – Date _____	☐ No	☐ Unsure
Shingles	☐ Yes – Date _____	☐ No	☐ Unsure
Whooping Cough	☐ Yes – Date _____	☐ No	☐ Unsure

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

☐ Yes ☐ No ☐ Unsure

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

_____

_____

_____

Cholesterol: When was the last time you had a cholesterol check _____

What was the level (if known) _____

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

Female – When did you last have?

Pap smear	Date _____	☐ Unsure	☐ Never
Breast check	Date _____	☐ Unsure	☐ Never
Mammogram	Date _____	☐ Unsure	☐ Never
Skin Check	Date _____	☐ Unsure	☐ Never

Males – When did you last have?

An Overall check up	Date _____	☐ Unsure	☐ Never
A Prostate check	Date _____	☐ Unsure	☐ Never
Skin Check	Date _____	☐ Unsure	☐ Never

Sun Protection – How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐