## ***Wyee Medical Centre -*** *New Patient Information Form*

| | |
|---|---|
| Surname | |
| Given Name/s | |
| Title **Please Tick** | Mr Mrs Ms Miss Mast Dr Other |
| Date of Birth | |
| Status **Please Tick** | Single Married De Facto<br>Widowed Other |
| Address | |
| Suburb | |
| | State Postcode |
| Email Address | |
| Contact Phone Number | Home |
| | Mobile |
| | Work |
| Medicare Number | Ref No. Expiry |
| Pension No or DVA No | No.<br>Expiry |
| Type of Card | |
| Private Health Fund | Fund<br>Policy No. |
| Ethnicity **Please Tick All Appropriate** | Australian, Non-Indigenous<br>Aboriginal<br>Torres Strait Islander<br>Other, Please Identify: |
| Identify As: **Please Tick** | Female Male<br>Other - **Please Identify:** |
| Next of Kin | Name |
| | Address |

| | |
|---|---|
| | Phone Number |
| | Relationship to You |
| Occupation | |
| Exposure to Hazardous Substances in Occupation Held by Patient | **Please Circle** Yes / No |
| If Yes, Please Identify | |
| Family Medical History | **Please Circle** **Mother** **Father**<br>Diabetes: Yes / No Yes / No<br>Asthma: Yes / No Yes / No<br>Stroke: Yes / No Yes / No<br>Heart Attack: Yes / No Yes / No<br>Cancer: Yes / No Yes / No |
| Your Medical History | **Please Circle**<br>Diabetes: Yes / No<br>Asthma: Yes / No<br>Stroke: Yes / No<br>Heart Attack: Yes / No<br>Cancer: Yes / No |
| Are you on any Medication? | **Please Circle**<br>Yes / No |
| Do you suffer from any Allergies? | **Please Circle**<br>Yes / No<br>List: |
| Do you smoke Tobacco or use Drugs? | **Please Circle**<br>Yes / No |
| How many per day/or when ceased? | |
| Do you drink Alcohol? | **Please Circle**<br>Yes / No |
| | **Please Circle**<br>Less than Monthly Monthly<br>Weekly Daily |
| If yes, how many standard drinks? | |
| Do you currently / OR have you vaped? | **Please Circle**<br>Yes / No |
| How many per day / OR when ceased? | |

**Patient or Guardian's Signature: …….. Date: ……..**