Wyee Medical Centre

New Patient Information. Pg 1 **Record your answers on this side**

Surname	
Given Name/s	
Title Please tick	Mr Mrs Ms Miss Mast Dr Other
Date of Birth	
Status Please tick	Single Married De Facto Widowed Other
Address:	
	State Postcode
Email Address:	@
Contact Phone number:	Home
Mobile	Work
Medicare Number:	Ref no. Expiry:
Pension No or DVA No:	No. Expiry:
Type of Card:	
Private Health Fund:	Fund: Policy No:
Ethnicity: Please tick all appropriate	Australian, Non-Indigenous Aboriginal Torres Strait Islander Other, please identify.
Identify as: Please tick	Female Male Other – Please identify:
Next of Kin:	Name:
	Address:
	Phone Number:
	Relationship to you:
Emergency Contact:	Name:
	Address:
	Phone Number:
	Relationship to you:

Wyee Medical Centre

New Patient Information pg 2.

Record your information this side

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 Diabetes: Yes / No Yes / No Asthma: Yes / No Yes / No Stroke: Yes / No Yes / No Heart Attack: Yes / No Yes / No Cancer: Yes / No Yes / No
Your Medical History	Please Circle Diabetes: Yes / No Asthma: Yes / No Stroke: Yes / No Heart Attack: Yes / No Cancer: Yes / No
Are you on any Medication:	Please Circle Yes / No
Do you suffer from any Allergies	Please Circle Yes / No List:
Do You Smoke Tobacco or Use Drugs	Please Circle Yes / No
Have you Ever Smoked or used drugs	Please Circle Yes / No
How many per day/ or when ceased	
Do you Drink Alcohol	Please Circle Yes / No
	Please Tick Less than monthly Monthly Weekly Daily
If yes, how many standard drinks	
Do you currently / OR have you Vaped How many per day/ or when ceased	Please Circle Yes / No

Form 1.2 Version 2

Patient or Guardian's signature: ..... Date: .....