The Local Doctor NEW PATIENT FORM – ADULT

Title	F	irst Name		Surname			PH:	
Date of	Birth	/	/	Male	Female			
Home A	\ddress:							Post Code:
Medica	re Card N	lumber:		Refe	rence number r	ext to your nar	ne:	Expiry:
•		Healthcare Number:	Card D	VA Card	Pension Card Expiry:			
Ethnicit Other E		. 0	orres Strait Island d:	der Aboriginal a	and Torres Strai Do you	t Islander No require an Inte	n ATSI rpreter? \	res/no
What a	re you all	lergic to:						
Do you Name: Relation Phone (Email:	nship:	r family mem	bers registered a Phone (W		Phone ((M):		
Marital	Status:	Single	Married	Divorced	Separated	Widowed	D	efacto
Country	of Birth	:			Citizenship:			
Occupa	tion:							
Name: Phone (Relationship: Phone (M):			hone (H):	
	-	ar about us?	Google	Word of mouth	Social	media 🔃	Walking/	driving by 🗌
Sometin informa concerr will be o	s. This informes this informes this intion. All ins, question of the second sec	formation is usinformation repersons acce ons or complants accertors or complants as ervice to complants.	usually collected needs to be share ssing your health aints about any ontact you via SN	from the patient ed with other hea n information are issues related to t //S regarding your	but also from fa lth care provide bound by confic the privacy of yo recall appointn	amily members ers or we may be dentiality. Pleas our personal info nents.	and other e legally be se do not h formation	ormation from our health care providers. ound to disclose esitate to discuss any with your Doctor. We
-At our	clinic, it	is policy that	an appointmen	t is required to re	ceive your resu	lts.		
Please	circle to a	acknowledge	that you have re	ad and understoo	od our policy	YES		
- I give	permission	on for 'The Lo	ocal Doctor' to c	ontact me via: SN	1S and email Y	es No		
We sen	d SMS no	otifications to	remind you of y	our appointment	time and when	we have receiv	ed test re	sults or correspondence
- I give	permissio No	on for 'The Lo	ocal Doctor' to se	end my personal,	sensitive infor	mation to relev	ant health	n professionals via email
Patient	Signatur	e:			Date:			

Allergies:		
Medications:		
Medical History:		
SKIN CANCER RISK FACTORS		
Blistering sun burns?	YES/NO	
Previous solarium use?	YES/NO	
Outdoor occupation?	YES/NO	
Welding?	YES/NO	
Family history of skin cancer?	YES/NO	
Are you over 50 years old?	YES/NO	
Please consider booking in for	a full skin check if you answer	ed YES to any of the above
Exposure to dusts or other occupations h	YES/NO	
FAMILY HISTORY RISK FACTORS		
Weak bones (osteoporosis or broken bo	YES/NO	
Diabetes	YES/NO	
High blood pressure	YES/NO	

Thank you. This information helps you and your doctor plan your preventative health to keep you healthy and well.

Heart disease in male relatives under 50yo and female relatives under 60yo

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

If yes how are they related to you? _____

If yes how are they related to you? _____

If yes how are they related to you? _____

If yes how are they related to you? _____

If yes how are they related to you? _____

High cholesterol

Breast cancer

Bowel cancer

Lung cancer

Prostate cancer

Ovarian cancer