

# KEPERRA FAMILY PRACTICE NEW PATIENT FORM

## Personal Details

Title: \_\_\_\_\_ Full Name: \_\_\_\_\_  
Known As: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_  
Email: \_\_\_\_\_

Medicare Card: \_\_\_\_\_ Reference: \_\_\_\_\_ Expiry Date: \_\_/\_\_/\_\_  
Centrelink Concession: \_\_\_\_\_ Expiry Date: \_\_/\_\_/\_\_  
Department of Veteran Affairs:  
White Card: \_\_\_\_\_  
Gold Card: \_\_\_\_\_

Private Health Fund: \_\_\_\_\_ Membership number: \_\_\_\_\_

Next of Kin: \_\_\_\_\_

Next of Kin's phone number: \_\_\_\_\_

Alternate Emergency Contact: \_\_\_\_\_

Alternate Emergency Contact's phone number: \_\_\_\_\_

### Cultural Background:

Please circle: Are you Aboriginal / TSI / Aboriginal and Torres Strait Islander/ or Non-indigenous

Country of birth: \_\_\_\_\_ Language spoken: \_\_\_\_\_

Do you require and interpreter: Yes/No

## Personal Medical Information

Health History - Do you have or have you had a history of the following?

Asthma

Diabetes

Hypertension

Chronic Illness

Heart Disease

Mental Illness

Cancer

Any other Significant Illness:

\_\_\_\_\_  
\_\_\_\_\_

**Operations** - Please include most recent surgery and approximate dates:

---

---

---

**Current medications** - Please include over the counter medications and vitamins as well:

---

---

---

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

---

---

---

**Female Patients:**

Have you had a Pap smear? Yes / No (Please circle)

If yes, date of last Pap smear: \_\_\_\_\_

**Social History**

Do you smoke? Yes / No If yes, how many per day? \_\_\_\_\_

Do you drink alcohol? Yes / No

If yes, how many drinks per day on average? \_\_\_\_\_

**Adult Patients Immunisations:**

Have you had the following immunisations?

Tetanus Booster	yes / no	date _____
Hepatitis B	yes / no	date _____
Hepatitis A	yes / no	date _____
Influenza	yes / no	date _____
Pneumococcal	yes / no	date _____
Polio	yes / no	date _____

When was your last skin check? \_\_\_\_\_

**Childhood immunisations** - are immunisations up to date yes / no

If no please discuss with doctor

➤ Please complete this form before leaving the practice today and hand to reception or your Doctor. Please feel free to write down any questions you may have for the Doctor today. Thank you. ↵