WESTGATE HEALTH
co-op ltd

Entered MF
☐ Entered

Date: _____

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:		
Title	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Other	
Surname		
First Name		
Date of Birth		

Street Address		
Suburb and Post Code		
Home Phone		
Work Phone		
Mobile Phone		
Email		

Medicare Number & Ref	#:	Expiry:
☐ **DVA Gold** ☐ **DVA White** (Please tick which)	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Private Health Cover	Name: #:	

Next of Kin	

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.
Please let us know if you do not wish to receive these.

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

Do you wish us to contact you via SMS for appointment reminders etc?	
☐ Yes	☐ No

Patient Background

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.

Do you identify as someone from a culturally and/or linguistic diverse background?
☐ No ☐ Yes. Please elaborate: Languages spoken:

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?
☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait Islander

Do you have or have you had a history of the following? (please elaborate)
☐ Operations
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other
Do you have any allergies or are you sensitive to drugs or dressings?

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

Family History

Have any members of your family had: (please elaborate)	
☐ Heart Disease	☐ Asthma
☐ Diabetes	☐ Mental Illness
☐ Cancer	☐ Other

Social History

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ Never Smoked ☐ Yes. Number ____ day / ____ week **or** ☐ Ex-smoker Quit Date: _____
Alcohol	How often do you have a drink containing alcohol? ☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4+ times/week How many standard drinks containing alcohol do you have on a typical day? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+ Are you concerned about your drinking? ☐ Yes ☐ No ☐ Don't know
Drug Use	☐ No. ☐ Yes. Type _____ / Frequency _____

Measurements

Height	_____ cm
Weight	_____ kg

Nutrition

Fruit	How many serves of fruit to do eat per day? ☐ 0 ☐1-2 ☐ 3-4 ☐ 5+
Vegetables	How many serves of vegetables to do eat per day? ☐ 0 ☐1-2 ☐ 3-4 ☐ 5+

For those 65 years and older:

When was the last time you were immunised?			
Influenza	Date:	☐ Not sure	☐ Never
Pneumococcal pneumonia	Date:	☐ Not sure	☐ Never

Females

When did you last have?

Pap Smear	Date:	☐ Not sure	☐ Never
Breast Check	Date:	☐ Not sure	☐ Never