NEW PATIENT INFORMATION

*** Please return this form to Reception along with your Medicare card or Photo ID ***

Title: Given Names: Surname:

Preferred Name (if applicable): DOB: / / Gender:

Address: Suburb: Postcode:

Mobile: Home: Email:

Occupation: Ethnicity: Marital Status:

Do you identify as Aboriginal? **Yes/No** Do you identify as Torres Strait Islander? **Yes/No**

Are you registered for the Close The Gap Program? **Yes/No**

Medicare No: __ __ __ __ __ __ __ __ __ __ Reference No: (number beside name) _____ Expiry: ____/_____

Healthcare/Pension No: __ __ __ __ __ __ __ __ __ __ Expiry: ____/___/_____ DVA No: _____ White/Gold

Next of Kin Name: Phone No.: Relationship:

Emergency Contact Name: Phone No.: Relationship:

Do you drink alcohol? **Yes/No** How many days per week? How many drinks per day?

Do you smoke? **Yes/No** How many per day?

Do you have any allergies? **Yes/No/Unknown** – if yes, please list with type of reaction:

Please list any current medications you are taking including over the counter and vitamins:

PERSONAL MEDICAL HISTORY (please circle if any of the following conditions are applicable to you)

Heart Disease Heart Attack Stroke Breathing Problems Psychiatric Disorder

Bleeding Disorder Cancer Diabetes Genetic Disorder

FAMILY MEDICAL HISTORY (please circle and provide family member)

Heart disease Heart Attack Breathing Problems

Diabetes Bleeding Disorder Cancer

Psychiatric Disorder Genetic Disorder

How did you hear about this practice? (Please circle) Google, Facebook, Word of Mouth, Street Signage, other.

CONSENT: -

I give consent for the following: - **(Please amend if you DO NOT give consent)**

✓ To be placed on any government recall register i.e. Pap register, Immunisation register, Breast screen etc.

✓ Contact via Email, Mail or Phone. This practice uses secured SMS **(HEALTH ENGINE)** to notify our patients with health messages, reminders, review appointments required and vaccinations. If you do not have a mobile device we will make contact with you via the numbers you provide.

✓ Consent to collect and report de-identified information.

✓ **This practice has a Non Attendance Policy. Non-Attendance without a valid reason will attract a $50 fee. If you are unable to attend an appointment, please contact us as soon as possible. By signing below I understand & acknowledge this Policy.**

My Health – this practice can upload your information to your "My Health" file. Please speak to your Doctor if you would like your medical records uploaded. For more information on My Health please visit – www.myhealthrecord.gov.au

In compliance with the Privacy Act, we require your consent for the treating Doctors to use the information provided on this form. This and additional information may be provided to other Doctors and/or Specialists when requesting medical imaging, pathology etc., or when referring you on. Patient information will not be released to family members without the patient's written consent. Doctors and staff will not discuss test results over the phone. It is your responsibility to arrange a follow up appointment to discuss your results. Occasionally your consult may include the presence of a medical student or GP Registrar as our doctors are actively engaged in teaching training doctors. All persons accessing your personal health information are bound by confidentiality. Please DO NOT hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your doctor.

Signature of Patient or Guardian: _____Date: ____/____/_____

1.INSTRUCTIONS:

Please answer the questions as they relate to the person being evaluated. A complete accurate record is important in learning about your allergy problem.

Briefly describe the reason for your allergy visit and what you hope to accomplish:

_____

_____

_____

_____

2. PROBLEMS:

Have you ever had the following conditions?

YES	NO	(Please check ALL Items)	Age of onset	Severity			Comments
				Mild	Moderate	Severe	
		Asthma (Wheezing)					
		Any other Breathing Problems					
		Sinus Trouble					
		Hayfever (runny, stuffy, Itchy nose, sneezing)					
		Hives or swelling					
		Eczema or other rashes					
		Food reactions					
		Drug reactions					
		Insect reactions					
		Frequent infections					

3. SYMPTOMS

Have you ever had any of the following? If No, leave blank.

	How Many Days in the last month?	Severity			Circle the Months Most Severe											
		Mild	Moderate	Severe	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Runny or Stuffy Nose																
Itchy Nose																
Sneezing																
Itchy Eyes																
Wheezing																
Coughing																
Wheezing or coughing with Exercise																
Skin Problems																

4. FOOD REACTIONS

Have you ever had any symptoms (rash, hayfever, vomiting, gas, cramps, diarrhoea or colic as an infant) after the ingestion of any food or liquid? If yes, specific below:

Food	Approximate Date	Symptoms	Can food be eaten?		Date food was last eaten
			Yes	No	

5. PRECIPITATING FACTORS / TRIGGERS

For each item below, check the appropriate circle to indicate whether your (or your child's) condition is affected by the following precipitants / triggers.

	Condition Made Worse	Condition Improved	No change		Condition Made Worse	Condition Improved	No change
Cutting or playing in grass, raking leaves	○	○	○	Other strong odours Specify:	○	○	○
High winds, thunderstorms	○	○	○	Exposure to animals Specify:	○	○	○
Other outdoor exposure	○	○	○	"Colds" or viruses	○	○	○
Mouldy / mildewed areas or items (basement etc)	○	○	○	Physical exertion or exercise	○	○	○
Sweeping, dusting or vacuuming	○	○	○	Cold weather	○	○	○
Smog, smoking or smoke exposure	○	○	○	Other factors: specify	○	○	○
Tobacco smoke	○	○	○				
Air conditioning or heating	○	○	○	Medications:	○	○	○
				• Antihistamines or cold preparations	○	○	○
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, tooth paste, etc. Specify:	○	○	○	• Asthma medications	○	○	○
				• Nose drops or sprays Specify:	○	○	○

Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilisers, inspect sprays, cooking odours, etc. Specify:	◯	◯	◯	•Aspirin •Other medications Specify:	◯	◯	◯

6. RESIDENCE

List your past residences with your most recent first. Only City and states required.

City & state	# of years	Effect on symptoms (better, worse, no change)
1.		
2.		
3.		
4.		
5.		

7. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy blood tests?

◯ Yes ◯ No If yes, date_____Doctor's Name_____

Results of these tests: (If possible, please provide us with a copy)

_____

_____

_____

Have you ever had allergy skin tests?

◯ Yes ◯ No If yes, date_____Doctor's

Name_____

Results of these tests: (If possible, please provide us with a copy)

_____

_____

Have you ever received allergy injections?

◯ Yes ◯ No If yes, give dates_____

Doctor's Name_____

Please list all medications you have taken for allergies in the past

_____

_____

_____

8. Patient Medical History: Please list any current or past medical conditions or operations

Condition	Yes	No	Condition	Yes	No	Operation	Yes	No	Others
Asthma			**Heart Disease**			**Skin Cancer**			
Diabetes			**Heart Attack**			**Appendix**			
Blood Pressure			**Stroke**			**Gallbladder**			
Cancer (Type)			**Bleeding Disorder**			**Orthopaedic**			
Nasal polyps			**Colic or spitting up as an infant**			**Hearing problems**			
Sinus operation			**Frequent diarrhoea**			**Glaucoma**			
Pneumonia, number past year_____			**Frequent heart burn**			**Tonsils / adenoids removed**			

9. IMMUNIZATIONS: (List dates and reactions, if any)	
Polio	**Measles**
DPT	**Rubella (German Measles)**
Tetanus Booster	**Influenza**
Pneumovax	**Others**

10. HOSPITALISATIONS		
List most recent first	**Reason**	**Date**
1._____		
2._____		
3._____		
4._____		
5._____		

11. SURGERY		
List most recent first	**Reason**	**Date**
1._____		
2._____		
3._____		
4._____		
5._____		

12. FAMILY HISTORY			
Do any members of your family have a history of allergy?			
	Yes	**No**	**If yes, list all relatives (e.g. parents, brothers & sisters, children, aunts, uncles, grandparents etc).**
Asthma			
Hayfever			
Eczema			
Hives			
Swelling			
Frequent pneumonia			
Other allergies			

Other Family Medical History: Please list any of the following conditions in your family

Condition	Yes	No	Who	Condition	Yes	No	Who	Others
Heart Disease/Attack				**Bleeding Disorder**				
Stroke				**Cancer (Type)**				
Diabetes				**Glaucoma**				
Thyroid Disease				**Genetic Disorder:(Type)**				

13. ENVIRONMENT SURVEY

Age of house **years**	**Number of indoor plants**
Are any rooms damp or musty?	**Do you have:** (a)An air cleaner? (b)An air humidifier?
Type of air conditioning (central, window et)	**Type of heating (central, electric etc)**

Type of Carpet	**Bedrooms**	**Living rooms**	**Dining rooms**
(synthetic, jute)			

How old is your:	Pillow?		**Do you have any:**	Stuffed furniture?
	Mattress?			Feather comforters?
Is your pillow:	☐ feather	☐ foam rubber	**Is your mattress:**	☐ foam rubber ☐ cotton
	☐ dacryon	☐ other:		☐ Innerspring & cotton ☐waterbed
	☐ encased in plastic			☐ encased in plastic ☐other:

What kinds of grasses, shrubs and trees are in the immediate vicinity of your house?

Do you have pets?	**Do your pets spend time indoors?**
	☐ Yes
List number and kind (dog, cat, birds, horses, etc)	☐ No

Are you exposed to anything at work that might aggravate your condition? Which things?

Have you missed any time from work or school because of your allergies? How much time?

Do you have any other exposure from hobbies, recreational activities? etc?