INVESTIGATOR CLINIC - Patient Registration Form

Welcome to the Investigator Clinic - we are committed to providing our patients with the best care; to do this it is essential that your medical records are up to date and accurate.

RECEPTION – Administrative details. *Please assist us by completing the following*

Surname			Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master	
First Name			Second Name		
Preferred Name			Date of Birth Gender		
Street			Postal Address		
Suburb					
State		Post Code		Home/Work Ph Mobile Ph	
Email Address			Skype Address		

Medicare Care	☐☐☐☐ ☐☐☐☐☐ ☐	Ref		Expiry Date	
DVA Card	☐☐ ☐☐☐☐☐☐	Type		Expiry Date	
Health Care		Grant Date		Expiry Date	
Senior Health		Grant Date		Expiry Date	
Pension Card		Grant Date		Expiry Date	

Marital Status	☐ Single ☐ Married ☐ Divorced ☐ De Facto ☐ Widow		
Country Of Birth		Ethnicity	

To assist with health initiatives – are you of Aboriginal or Torres Strait Islander origin?

☐ Yes - please specify ☐ N/A	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait	Are you registered with CTG **YES** / **NO**

Next of Kin	Name	Relationship	Phone
Emergency Contact	Name	Relationship	Phone

Do you have any allergies or sensitivities to medications or dressings? ☐ Yes (please list below) ☐ No known allergies

_____

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Office Use Only	*Status - Visitor/Regular*	*Payment Level - BB/PR/R/NPFC*
IHI - ☐ Medicare update ☐	*Patient Alert – PEN/HCC/SHC/DVA NPFC or N/CO*	*Medical Warning – NKA ☐*
Cards Sighted	*Staff Name/Signature*	

Patient Registration Form – Clinical Information to be completed by patient and given to your doctor

Patient's name …… Date of birth ……

Are you sensitive to any medications or dressings? ☐ Yes (please list below) ☐ No known allergies

_____

_____

Children's immunisations – if completing this form for a child are their immunisations up to date? ☐ Yes ☐ No

Your Health History - current or past:- do you have (or have you had) a history of:-

- ☐ Heart Disease –eg. Heart attack, angina, cardiac operation
- ☐ Stroke/ aneurysm
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension/high blood pressure
- ☐ High cholesterol
- ☐ Cancers (breast, ovaries, skin, bowel, melanoma, prostrate)
- ☐ Mental Health Issue
- ☐ Coeliac disease
- ☐ Haemachromatosis
- ☐ Other – please specify

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Current Medications (including over the counter medications, vitamins & minerals)

_____

_____

_____

_____

Have you had any operations? (such as cardiac surgery, appendix, tonsils, hysterectomy, gall bladder) – please specify

_____

_____

_____

Have you ever been hospitalized and why? – please specify

_____

_____

_____

Have you ever had any anesthetic complications? – please specify

_____

_____

_____

Have you had any fractures? – please specify

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_____

Patient Registration Form – Clinical Information to be completed by patient and given to your doctor

Patient's name …… Date of birth ……

Family History

Please specify relation – whether on father or mother's side of the family, age at diagnosis, age at death.

- ☐ Heart Disease –eg. Heart attack, angina, cardiac operation
- ☐ Stroke/ aneurysm
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension/high blood pressure
- ☐ High cholesterol
- ☐ Cancers (breast, ovaries, skin, bowel, melanoma, prostrate)
- ☐ Mental Health Issue
- ☐ Coeliac disease
- ☐ Haemachromatosis
- ☐ Other – please specify

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Social History

- ☐ Tobacco _____ day / week or ceased smoking – date _____
- ☐ Alcohol _____ day / week / month (circle applicable)
- ☐ Drug use _____ (type & frequency)

Females: - When did you last have:-

Pap smear	Date _____	☐ not sure	☐ never
Breast check	Date _____	☐ not sure	☐ never
Bone Density test	Date _____	☐ not sure	☐ never
>50 Faecal Occult Blood Screen	Date _____	☐ not sure	☐ never

Number of children – *if applicable* _____

Males: - When did you last have:-

Overall check up	Date _____	☐ not sure	☐ never
>50 Faecal Occult Blood Screen	Date _____	☐ not sure	☐ never

Anything else your doctor should know or you would like them to know?

_____

_____

_____

Please take this form in with you to your consultation and give it to your doctor

Date …… ***Doctor's cert.*** ……..