

MEDICATIONS

Please list all current medications including vitamins, herbal medicine and over the counter medications and doses if known

ALLERGIES

Please list any known allergies

HISTORY

Please list any medical history and past operations, illnesses and injuries

IMMUNISATIONS

- Childhood vaccines up to date
- Pneumococcal (Pneumonia) Date: _____
- Influenza Date: _____
- Tetanus Date: _____
- Other (Please specify) _____ Date: _____

WOMEN'S HEALTH:

Last Cervical Screening Test:
Last Mammogram (If over 50):

MEN'S HEALTH:

Last Prostate Check (If Over 50):

LIFESTYLE HEALTH HISTORY:

- Smoking:
- Never
 - Ex-Smoker – quit date: _____
 - Current smoker - _____ per day

- Alcohol:
- Non-Drinker
 - Rarely/Light
 - Moderate
 - Heavy

FAMILY HISTORY

- | | | |
|---------------|------------------------------|------------------------------|
| Diabetes | <input type="checkbox"/> Mum | <input type="checkbox"/> Dad |
| Heart Disease | <input type="checkbox"/> Mum | <input type="checkbox"/> Dad |
| Stroke | <input type="checkbox"/> Mum | <input type="checkbox"/> Dad |
| Depression | <input type="checkbox"/> Mum | <input type="checkbox"/> Dad |
| Cancer | <input type="checkbox"/> Mum | <input type="checkbox"/> Dad |

- Other : _____
- Other : _____
- Other : _____
- Other : _____
- Other : _____

Please specify cancer type:

NEW PATIENT CONSENT FORM

Patients Name: _____

Y / N I consent to receiving recalls and reminders regarding my personal health care and medical treatment

Y / N I consent to the use of my personal health information by Bacchus Marsh Medical Centre and other health providers involved in my medical treatment and health care

Y / N I consent to the disclosure of my personal health information by the Bacchus Marsh Medical Centre to other health providers involved in my personal health care or medical treatment

Y / N I consent to the use of my de-identified information for research purposes

Signature: _____

Parent / Guardian Name: _____

Date: _____