



PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DOB: ___/___/___

Do you suffer from any of the following? Please indicate:

	YES	NO		YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart ailment	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, chest or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or bowel problems (e.g. ulcer)	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis or bone tumour	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or drink?	<input type="checkbox"/>	<input type="checkbox"/>	How many a day? _____/day		

List any previous illness: _____

List any other Medical conditions the doctor should be aware of: _____

Do you have an artificial hip, heart valve or other prosthetic implant? _____

Are you taking any drugs, medicines or tablets? If yes, please list.

Are you pregnant? How many weeks? _____

Do you have any allergies?

Please list any medicines or products you are allergic to (e.g. Penicillin, latex, etc)

Date of your last:
Pap Smear: _____ Breast Check: _____ Prostate Check: _____

Weight: _____ Height: _____

Do members of your family suffer from any medical condition which the doctors should be aware of? (e.g. heart disease, cancer, diabetes, etc)



NEW PATIENT INFORMATION FORM

Medicare number: _____ Ref number: _____ Expiry date: ___/___/___

Health Care Card / Pension Card Number: _____ Expiry date: ___/___/___

Title: Mr / Mrs / Ms / Miss

Surname: _____ Given name: _____

DOB: ___/___/___ Occupation: _____

Contact Details:

Address: _____

_____ Postcode: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Email address: _____

Next of Kin:

Name: _____ Contact number: _____

Emergency contact:

Name: _____ Contact number: _____

Do you agree to have reminder letters (e.g. immunisations, etc) to be sent to your address? YES / NO

Do you agree to have contact made at the phone numbers listed above? YES / NO

Do you agree to have messages left on your answering machine in your absence? YES / NO

Do you identify as someone from a culturally diverse background? If yes, state origin country & year arrived

To assist with health initiatives, are you Aboriginal or Torres Strait Islander? YES / NO

If yes, please indicate which one: ABORIGINAL / TORRES STRAIT ISLANDER

I declare that the information given is true and I consent to HFMC's information use and privacy policy.

Signed: _____

Date: ___/___/___

15/1647 Burwood Highway Belgrave VIC 3160

Phone: 03 9752 6111 Fax: 03 8678 1126

Email: hfmcfax@gmail.com