PLEASE EMAIL TO HFMCFAX@GMAIL.COM AFTER COMPLETION

HILLSCENE FAMILY MEDICAL CENTRE

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DOB: ___/___/____

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

	YES	NO		YES	NO
High blood pressure	☐	☐	Diabetes	☐	☐
Heart ailment	☐	☐	Depression	☐	☐
Rheumatic fever	☐	☐	Excessive bleeding or blood disorder	☐	☐
Asthma, chest or breathing problems	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
Stomach or bowel problems (e.g. ulcer)	☐	☐	AIDS/HIV	☐	☐
Kidney disease	☐	☐	Osteoporosis or bone tumour	☐	☐
Do you smoke or drink?	☐	☐	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)

15/1647 Burwood Highway Belgrave VIC 3160
Phone: 03 9752 6111 Fax: 03 8678 1126
Email: hfmcfax@gmail.com

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HILLSCENE FAMILY MEDICAL CENTRE

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

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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: ____/____/____

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