



# NEW PATIENT INFORMATION FORM

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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.

Could you please assist us by completing the following?

Surname		First Name		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Date of Birth:		Home Phone			
Street No. & Address		Suburb & P/Code			
Work Phone		Mob. Phone			
Medicare No:		Expiry Date			
DVA Gold/White		Expiry Date			
Pension/Health Card No:		Expiry Date			
Next of Kin Name/ Emergency Contact		Next of Kin Telephone No:			
Next of Kin Relationship		Email			

To assist with health initiatives - Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes ☐ No If yes, please specify which one or both: \_\_\_\_\_

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes (If yes please list below) ☐ No

## Social History

Occupation \_\_\_\_\_

## Country of Birth

\_\_\_\_\_

## Cultural Background

Smoker: ☐ Yes ☐ No If yes, how many a day / week \_\_\_\_\_ or Ex-Smoker ☐ Quit Smoking  
Date: \_\_\_\_\_ Never Smoked ☐

Alcohol: ☐ Yes ☐ No

If yes, how many standard drinks per \_\_\_\_\_ day / week / month (circle the one applicable)

☐ Drug use: \_\_\_\_\_ (type and frequency)

**Marital Status** ☐ Single ☐ Married ☐ De-facto ☐ Divorced ☐ Separated ☐ Widowed

**Height:** \_\_\_\_\_ cms **Weight:** \_\_\_\_\_ kgs

## Your Health History - Do you have or have you had a history of? (Please tick)

☐ Diabetes ☐ Asthma ☐ Hypertension ☐ Operations  
☐ Chronic illness ☐ Depression/Mental Illness ☐ Other ☐ Nil Known

## Family History - Have any members of your family had? (Please tick)

☐ Diabetes ☐ Asthma ☐ Cancer  
☐ Heart Disease ☐ Mental illness ☐ Other ☐ Nil Known

THANK YOU