NEW PATIENT FORM – LYNWOOD MEDICAL

We are committed to providing our patients with the best care. To do this it is essential that your personal information is correct and up to date.

Title:(circle) Mr, Mrs, Ms, Miss, Mst, Dr

Surname: _____First name: _____Preferred name: _____

Date of Birth: _____/____/____ Birth Sex: Male ☐ Female ☐ Gender Identity:_____

Occupation: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Defacto ☐ Widow/Widower ☐

Are you a former serving member of the Australian Defense Force? Yes ☐ No ☐

Do you identify as being of: Aboriginal descent?: Yes ☐ No ☐

Torres Strait Islander descent? Yes ☐ No ☐ Is English your second language?: Yes ☐ No ☐

Ethnicity/ Country of Origin: _____ (e.g. Irish, Chinese, English)

Do you require an interpreter? Yes ☐ No ☐

Address: _____

Postcode: _____ State: _____Phone: _____

Postal Address: _____

Mobile: _____ Work:_____ Email: _____

Do you consent to receiving appointment and clinical reminders and by SMS? Yes ☐ No ☐

BILLING: Medicare No: _____ Line No: _____ Expiry_____

DVA Gold Card #: _____DVA White Card #: _____

Pension/Health Card/Seniors Card: _____ Expiry: _____

PATIENT'S NEXT OF KIN

Name: _____ Relationship to patient: _____

Phone: _____ Mobile: _____ Work: _____

Lynwood Medical & Natural Health Centre
Suite 6, Level 1, 2 Bungan Lane, Mona Vale 2103
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Reviewed 01/12/2021

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Phone: _____ Mobile: _____ Work: _____

ALLERGIES

Do you have any allergies or are you sensitive to drugs or dressings?: Yes ☐ Nil known ☐

(if yes please list below)

_____

YOUR HEALTH HISTORY

Do you have or have you had a history of? ☐ Operations or fractures (year if known)

_____

☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Cancer

☐ Chronic Disease or major illness (list)

_____

_____

☐ Other

_____

MEDICATIONS

Please list all medications including vitamins and herbal medicines:

_____

_____

IMMUNISATIONS

☐ Pneumococcal (pneumonia) - Year: _____ ☐ Influenza - Year: _____

☐ Tetanus - Year: _____ ☐ Whooping Cough - Year: _____

☐ Covid 19 - Year: _____ ☐ Childhood vaccination up to date (record or blue book please supply if able)

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WOMEN'S HEALTH

Last Pap smear: _____ Last mammogram: _____ (if aged over 50)

Breast Check: _____

MEN'S HEALTH

Last prostate check: _____ (if aged over 40) An overall checkup: _____

SMOKING HISTORY

☐ I have never smoked ☐ Former smoker – Quit date: _____

☐ Current smoker - number per day/week: _____☐ Number of years smoking: _____

☐ Vaping – number per day/week: _____ ☐ Number of years vaping: _____

ALCOHOL HISTORY

☐ I do not drink alcohol **Past Alcohol Intake**: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Current Alcohol Intake:

☐ Rarely, light Days per week: _____Standard drinks per day: _____

☐ Moderate Days per week: _____Standard drinks per day: _____

☐ Heavy Days per week: _____Standard drinks per day: _____

SIGNIFICANT FAMILY HEALTH HISTORY (please tick)

Mother

☐ Diabetes ☐Hypertension ☐Heart disease ☐ Stroke ☐ Colon Cancer ☐ Depression

☐ Breast Cancer

Father

☐ Diabetes ☐Hypertension ☐Heart disease ☐ Stroke ☐ Colon Cancer ☐ Depression

CARE PLAN (please tick)

Do you have an Advanced Care Plan in place? ☐ Yes ☐ No

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Reminders

As part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due We also participate in state /territory reminder systems. I consent to receive follow up reminders and recalls. (If you do not wish to participate please inform your doctor)

Cancellation

A minimum of 2 hours' notice is required for cancellation of appointments. As we are a very busy practice more than 2 missed appointments without notice will incur a non-rebate cancellation fee.

Your privacy is our concern

In accordance with the Privacy Act, all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with this Act. We use this information you provide to manage your health care.

Selected information may be disclosed to various other health services involved in supporting your health care management. (e.g. pathology, specialists, immunisation registers)

If you have any questions or concerns how we handle your personal health information or need to arrange access to your records, please ask the staff or you doctor, as appropriate.

Patients signature or Parent/Guardian (if child is a minor)

_____

Date: _____ Name: _____

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