Knoxfield and Colchester Medical Centres

310 Colchester Road, North Bayswater Vic 3153
34 Riddell Road, Wantirna South Vic 3152

New Patient Medical History

Patient Details

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname: ______________________ **First Name:** ______________________

Date of Birth: _______/_______/__________

Street Address: ____

Suburb: ______________________ **Postcode:** ______________________

Phone: H ________________ W ________________ M ________________

Email: ____

Concession Cards

Medicare Card Number ______________________ Ref ______ Expiry:__________

Pension/HCC Number ______________________________ Expiry:__________

DVA Card Number ______________________________ Expiry:__________

Next of Kin

Name: ________________ Relationship: ______________ Phone: ____________

Emergency Contact (if different to Next of Kin)

Name: ________________ Relationship: ______________ Phone: ____________

Past Medical Records/History

Would you like to transfer your past medical records/history to KCMC?

☐ No ☐ Yes, from: ____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds, do you identify as someone from a culturally and/or linguistic diverse background?

☐ No ☐ Yes ____

Are you an Aboriginal or Torres Strait Islander?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Please Turn Over

Reminder Systems
Our practice provides our patients with preventive care and early case detection reminders (e.g. immunisations, annual health checks, skin checks and pap smears)
Do you agree to have relevant health reminders sent to you: ☐ Yes ☐ No
If yes, I prefer to have reminders sent via ☐ Email ☐ SMS ☐ Post

Your records will be uploaded to My Health Record unless you opt out of this.
I agree to using My Health Record ☐ Yes ☐ No

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

☐ No ☐ Yes ____

Do you or have you had a history of the following? (please elaborate)

☐ Operations ____________________ ☐ Asthma ____________________

☐ Diabetes ____________________ ☐ Hypertension ____________________

☐ Chronic Illness ____________________ Do you smoke? ☐ Yes ☐ No

☐ Other: ____

Immunisations
Have you had the following immunisations? (List date where appropriate)

Tetanus Booster	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis B	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis A	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Influenza	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Pneumococcal	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Polio	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know

Children's Immunisations
If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

Current Medications
Please list all current medications including over the counter medications, vitamins and minerals:

____________________ ____________________

____________________ ____________________

____________________ ____________________

Is there anything else you would like your doctor to know?

____

____

Signed: ______________________________ Date: _____/_____/_____