Casuarina Health & Medical – Adult patient information form

Thank you for completing the following 2 pages:

Title (Please circle)	**Mr**	**Mrs**	**Ms**	**Miss**	**Master**
Surname	**Gender:**			
First & Second Names	**Preferred Name**			
Date of Birth				
Address				
Postal address **(If different to above)**				
Telephone Numbers	Home:	Mobile:	Work:	
Medicare Number		**Ref #**	**Expiry Date**	
Veterans' Card Number: **Gold / White / Orange** **(Please circle)**			**Expiry Date**	
Pension Card Number			**Expiry Date**	
Health Care Card Number			**Expiry Date**	
Next of Kin	**Name:**		**Phone number:**	
	Relationship to you:		**Address:**	
Emergency Contact Person **(If different to above)**	**Name:**		**Phone number:**	
	Relationship to you:		**Address:**	

What is your ethnicity? (e.g. Australian, British, Canadian, New Zealander)

- Please specify ……

Do you identify as Aboriginal or Torres Strait Islander? (please circle)

- Aboriginal
- Torres Strait Islander
- Aboriginal & Torres Strait Islander
- Neither Aboriginal nor Torres Strait Islander

We contact patients by SMS text message/phone and/or send out recall letters for test results and for ongoing patient care. Please sign below to give permission to be included in our recall system.

Signature:…… **Date:**……

Doctors at Casuarina Health & Medical are required to participate in research for quality assurance. To enable them to do this, they need permission to use de-identified medical information from patient's medical records. Please sign below to give permission for your de-identified medical data to be used for this specific purpose only.

Signature:…… **Date:**……

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***PATIENT NAME*:** ……

Height: …….. cm **Weight:** …….. kg

Marital Status (please circle) Single Married De facto Widowed Divorced

Occupation: ……

Do you need an interpreter service?

- Please specify ……

Any ALLERGIES or sensitivities to medications, dressings or foods? (please circle)

- No
- Yes - Please specify ……

Do you smoke cigarettes? (please circle)

- No, I've never been a regular smoker
- Not now, but I used to smoke
- Yes – how many every day on average? ……..

Do you drink alcohol? (please circle)

- Never
- Sometimes
- Weekly
- Daily

Do you have, or have you ever had, any medical problems? (please circle)

- Asthma
- Diabetes
- Heart disease
- High blood pressure
- High cholesterol
- Depression and/or anxiety
- Other – please specify ……

Current medications (including over the counter medications, vitamins & supplements):

1. …… **3.** …… **5.** ……
2. …… **4.** …… **6.** ……

Cancer screening:

- Have you ever had a full skin check? Yes No
- Patients aged 50 to 75, have you participated in bowel cancer screening? Yes No
- Ladies aged 20 to 70, when did you last have a Pap smear for cervical cancer screening? ……..
- Ladies aged 50 to 74, when did you last have a mammogram for breast cancer screening? ……..

In your family, does anyone have any medical problems? (please circle)

- Asthma
- Diabetes
- Heart disease
- Cancer
- Other – please specify ……
- High blood pressure
- High cholesterol
- Depression and/or anxiety