Warrawong Medical Centre **43 King Street, Warrawong NSW 2502**
Dr Michael O'Halloran Dr Peter Floro Dr Min K.K. Thaung Dr Richard Lee

To provide the best quality of care we need to maintain up-to-date information about your personal details. This health information is kept private and secure as required by Federal and State privacy laws. If you have any concerns please leave blank and discuss this with your doctor.
Please print clearly

NEW PATIENT DETAILS

Surname: _____ First Name: _____ Mr, Mrs, Ms, Miss Mst *(circle)*

Date of birth: ____/____/_____ Male: ☐ Female: ☐ Country of Birth: _____

Ethnicity: _____ Main language spoken at home: _____

Marital status: Single Married De-facto Separated Divorced Widowed *(circle)*

Occupation: _____ Employer:_____

Home address: _____

Postal address *(if different)*: _____

Telephone No: _____ (home) _____ (work) _____ (mobile)

Do you consent to receive "SMS" messages for appointment reminders and recalls: Yes ☐ No ☐

Medicare No: _____ Expiry: _____ Private Health Fund: _____

Pension / Health Care Card No: _____ Expiry: _____

Veterans Affairs No: _____

Do you identify yourself as one or both of the following:

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ No ☐

Do you need information on "Closing The Gap" Registration and Benefits? Yes ☐ No ☐

EMERGENCY CONTACT DETAILS

Name: _____ Relationship: _____

Telephone No: _____ (home) _____ (work) _____ (mobile)

SOCIAL INFORMATION

Do you drink alcohol? Yes ☐ No ☐ If yes, how much and how often?_____

Do you smoke? Yes ☐ No ☐ Have you ever smoked? Yes ☐ No ☐ Year Gave Up _____

If yes how many cigarettes or packets a day? _____

What type of exercise do you do? How many hours per week?

_____

Thank you for completing this information.
Please advise us if your contact information or Medicare details change in the future.

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YOUR HEALTH – *Please write on the back of the form if you need more room.*

Do you have any medical conditions? Yes ☐ No ☐

If so, what:

_____

_____

Allergies ☐ Nil known ☐

List all allergies and intolerances to medications:

_____

_____

List of other allergies:

_____

_____

Please list your current medications - prescribed and over the counter (e.g. vitamins, alternative medicines):

_____

_____

_____

Have you had any surgery, accidents or hospitalisations? If so, when and for what?

_____

_____

Do you have any tests/scans or x-rays of current problem? Yes ☐ No ☐

Have you ever suffered from: *(please tick)*

	Yes	No		Yes	No
Skin cancer			Chronic Fatigue Syndrome		
Heart disease			Cancer		
Chest pain			Osteoporosis		
Circulation problems			Diabetes		
Thrombosis / clots			Urinary infections		
Asthma / bronchitis / breathing difficulties			Bowel problems		
Dizziness, nausea or fainting			Arthritis		
Headaches / migraines			Bone fractures		
Liver disease / hepatitis			Incontinence		
Epilepsy			Dental or jaw complaints		

LIFESTYLE
Please list any significant family illnesses:

_____

_____

Form completed by and date: _____

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