



Main Street
MEDICAL SERVICES



156 MAIN STREET
GRENFELL NSW 2810
AUSTRALIA

+61 2 6343 1211

+61 2 6343 2107

receptionist.msms@gmail.com

NEW PATIENT INFORMATION

Title: _____ Surname: _____

First Name & Other Names: _____

Date of Birth: _____ Marital Status: _____

Address: _____

Town: _____ Post Code: _____

Telephone (Home): _____ Telephone (Mobile): _____ Telephone (Work): _____

Nationality: _____ Occupation: _____

Emergency Contact / Next of Kin: _____ Date of Birth: _____

Relationship: _____ Telephone: _____

DOCTOR IS UNABLE TO PRESCRIBE DRUGS OF ADDICTION TO NEW PATIENTS (e.g. Oxycontin)

Medicare #: _____ Ref #: _____

Expiry Date: _____

Veterans Affairs #: _____ Expiry Date: _____

Pension/HealthCare Card #: _____ Expiry Date: _____

Private Health Insurance Name: _____ Policy #: _____

PCEHR ID: (Personally Controlled Electronic Health Record) If Known: _____



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Do you give consent for Main Street Medical Services to contact you via SMS/Text Messages?: Yes/No

Do you give consent for Main Street Medical Services to identify themselves when leaving a message?
Yes/No

Do you give consent to be contacted at your work number? Yes/No

MEDICAL HISTORY QUESTIONNAIRE

(**CONFIDENTIAL**)

	AGE AT DEATH	CAUSE OF DEATH
Mother Still Alive? (Yes/No)		
Father Still Alive? (Yes/No)		

FAMILY MEDICAL HISTORY

(Please select Yes or No)

- ❖ Have you any close relatives who have heart disease before the age of 60? This includes cardiovascular disease, heart attack, angina or bypass surgery? - Yes/No
- ❖ Have any of your close relatives had diabetes, also known as Type II diabetes or non-insulin dependent diabetes? - Yes/No
- ❖ Do you have any close relatives who have had melanoma? – Yes/No
- ❖ Have any of your close relatives had bowel cancer before the age of 55? – Yes/No
- ❖ Do you have more than one relative on the same side of the family who have had bowel cancer at any age? And this includes your parents, children, siblings, grandparents, aunts, uncles, nieces, nephews and grandchildren – Yes/No
- ❖ Have any of your close relatives had ovarian cancer? – Yes/No
- ❖ Have any of your close male relatives had prostate cancer before the age of 60? – Yes/No
- ❖ Have any of your close relatives had breast cancer before the age of 50? – Yes/No
- ❖ Do you have more than one relative on the same side of your family who had breast cancer at any age? And this includes your parents, children, siblings, grandparents, aunts, uncles, nieces, nephews and grandchildren – Yes/No

PAST MEDICAL HISTORY

(Please Tick Box if you have ever had any of the following:)

Anemia	Migraines	Bleeding Disorder	Splenectomy
Asthma	Sinus Problems	Digestive Problems	Kidney Disease
Cancer	Vision Problems	High Blood Pressure	Liver Disease
Seizure	Hearing Loss	Tumor	Lung Disease
Hepatitis	Blackouts	Psychiatric	Bowel Disease
Diabetes	Convulsions	Emotional Problems	Heart Disease
Arthritis	Emphysema	Leukaemia	Prostrate



Other Medical Problems not listed above: _____

Past Surgeries/Procedures or Hospitalizations (Please include the year and details) :

Is there a history of any other significant illness in the family? Yes/No

If Yes, please indicate which family member and please provide details of condition:

Father/Mother/Sister/Brother _____

Prescription Medications (include name of medication, dose/strength, and how often you take it, e.g. lipitor 10mg once per day, ramipril 5mg two times per day):

Any Over the Counter, Vitamins or/and Herbal Products:

Do you take any recreational drugs: Yes/No

If Yes – please list -

IT IS EXTREMELY IMPORTANT TO COMPLETE THIS SECTION

Allergies

Please list any known allergies to any medication, food or other. i.e. anaphylaxis, rashes, swelling etc

Allergy To?	Type of Reaction?	Severity of Reaction?
		Mild / Moderate / Severe
		Mild / Moderate / Severe
		Mild / Moderate / Severe
		Mild / Moderate / Severe



Do you smoke?	Yes/No	If yes - How many sticks per day? _____	If no - Did you ever? Yes/No
Do you drink alcohol?	Yes/No	If yes - Number of drinks/week: _____	
Do you exercise?	Yes/No	If yes - How often? _____	

FOR WOMEN ONLY:

What year was your last Pap Smear? _____

Last Mammogram Date? _____

Are you currently pregnant? Yes/No/Unsure

Have you had a Hysterectomy? Yes/No

Finally, please bring all your **medications** and **immunization records** to your first appointment.

PATIENT'S ACKNOWLEDGEMENT OF PRIVACY INFORMATION

- * I have read the form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.
- * I understand that I am not obliged to provide any information requested of me.
- * I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.
- * I am aware that I have the right to access the information collected about me, except in some circumstances where access might legitimately be withheld.
- * I understand these circumstances will be explained to me.
- * I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- * I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.
- * Exceptions to the above are that I request the medical information be withheld from _____

* I consent to have any procedure performed at the surgery, which has been discussed between the doctor and myself.

Signature: _____ Date: _____

* I acknowledge that I have read this form before signing it and that a member of the staff of this practice has, at my request clarified any aspects of it that I did not at first understand.

Signature: _____ Date: _____

Patient/Guardian or Carers Name (*Please Print*): _____

Address: _____

Contact Number(s): _____ Date of Birth: _____

*** Please ask Reception if you would like your own copy of our Privacy Statement ***



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Client Consent to Release Information

Do you wish to give consent for the release of investigation results etc to a third party?
(e.g. child, spouse, carer) – Yes/No

If you wish to give consent, please complete below information.

I _____, Date of Birth: _____

authorise the release of my investigation results to:

Name: _____

Address: _____

Relationship to Client: _____

Patient's Signature: _____ Date: _____

