Brisbane City Doctors

Lower Level Manor Apartments
289 Queen Street
Ph: 07 3221 3366 Fax: 07 3221 3082
Website: www.brisbanecitydoctors.com.au

We request the following personal details for two purposes. Firstly we are legally required to maintain certain minimum information about our patients in addition to the medical records kept by your doctor. Secondly and more importantly, this information assists us to gain the best health outcomes for you by facilitating communication with specialists and with relatives in cases of medical emergency.

Patient Details

Date:

Mr/Mrs/Miss/Ms/Mstr _____ Sex: Male / Female

First Name _____ Surname _____

Aboriginal or Torres Strait Islander ***Yes / No*** Ethnicity: _____

Date of Birth _____ Marital Status : Single / Married /Divorced/De facto

Medicare Number _____ Reference _____ Expiry _____

Pension / HCC No _____ Expiry _____

Vet Affairs No _____ (Gold Card / White Card)

Street Number & Name _____

Suburb _____ Postcode _____

Home Phone _____ Mobile _____

Work Phone _____ Email Address _____

Occupation _____ Country of Birth _____

Emergency Contact

Emergency Contact Person _____ Phone (W/H) _____

Relationship _____ Mobile _____

Do you give us consent to leave messages with emergency contact if we can't reach you? ☐ YES ☐ NO

Next of Kin Contact Person _____ Phone (W/H) _____

Relationship _____ Mobile _____

Online Claiming

If you prefer for Medicare to pay your rebate back into your account, please register your bank account details with Medicare.

How did you hear about this practice?

☐ Yellowpages Online ☐ Google ☐ Yahoo ☐ Others _____

☐ Search Term_____ ☐ Business card

☐ Yellowpages in print ☐ Street Signage ☐ Word of Mouth ☐ Chemist

☐ Whitepages ☐ Other Medical Centre ☐ Other, please specify: _____

This practice participates in national/state or territory reminder systems/registers
Do you consent to health reminder letters/Emails / SMS? ☐ YES ☐ NO Signed: _____

I accept it is my responsibility to inform the Practice of any change to contact details

Signed by patient…… ……

OFFICE USE ONLY Entered by _____ Date: _____

PTO ➔

Family History

	Father	Mother	Father's Parents	Mother's Parents	Sibling	Children
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐

Other _____

Habit Check

Coffee _____ cups/day Alcohol _____ drinks/day or week

Cigarettes _____ no/day Physical Activity _____

Nutrition Issues _____

Drug Allergies

Medication _____ Reaction _____ Mild/ Moderate/ Severe

Medication _____ Reaction _____ Mild/ Moderate/ Severe

Medication _____ Reaction _____ Mild/ Moderate/ Severe

List all medications, vitamins, herbs, creams, potions, lotions you are taking/using

Current Medications

Current Health Problems

Past Health Problems

Thank you for your time. Please return this form to one of the receptionists