

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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