

Personal Details	Title: Mr/Mrs/Ms/Mast/Miss/Dr/Prof/Sir/Lady/Br/Fr/Sn/Other		
	Surname:		Given Name (s):
	Preferred Name:	Date of Birth:	Occupation:
	Gender Identity Female/Male/Non-Binary/Gender Diverse/Transgender/Different identity:		Gender: Female/Male/Other/Unknown
	Preference: he/him/his she/her/hers they/them/theirs		Marital Status:
Cultural	Knowing your cultural background can help us provide health care that meets your individual needs.		
	Are you of Aboriginal or Torres Strait Islander origin? No Yes, Aboriginal Yes, Torres Strait Islander Yes, Aboriginal & Torres Strait Islander		
	Other Cultural Backgrounds (Asian, African, Mediterranean etc)		Country of Birth:

Contact Details	Residential Address:		Suburb:
	Post Code:		Mobile Number:
	Home Phone:	Email Address:	
	Our practice uses a reminder system to help maintain your health. The practice sends reminders by post, email, telephone or SMS for appointments and procedures like vaccinations, cervical screening and other health reviews. I consent to being contacted with reminders to help me maintain my health. Signature: Yes No Appointments Only		

Health Cover	Medicare Number:	Ref:	Expiry:
	Pensioner/ Health Care Card Number:		Expiry:
	Pension Card Type:		
	DVA Number:	Gold White	Expiry:
	Do you consent to your medical records being uploaded to your 'My Health Record'? Yes No		

Next OF Kin	Name:		Relationship:
	Contact Number:		
	Emergency Contact Name:		Relationship:
	Contact Number		

Consent	We value your privacy. All information about you, at Era Doctors, is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988). We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information during your health care. I consent to the disclosure/use of my personal health information by Era Doctors to other health providers directly involved in my personal health care or medical treatment and that my health records may be used and de identified for shared patient data. I understand that declining to participate in research will not affect the care I receive at this practice. Do you consent to us contacting your Next of Kin in the event of an emergency or if you are unable to be reached? If you no longer require your appointment, we would appreciate you calling to cancel so the time may be made available to other patients. Failure to do so, prior to your appointment will result in your next visit to our centre being privately billed. I understand and consent to the above. YES NO	
	Signature	Date:
	Print Name:	

Name _____

Date of Birth: _____

Personal Medical History	Diabetes		
	Asthma		
	Operations		
	Hypertension		
	Chronic Illness		
	Other		

Do you have any allergies or are you sensitive to drugs or dressings? (Please list) Yes No

Allergies		

		Year	Current Medications:
Immunisations	Tetanus Booster		
	Hepatitis A		
	Hepatitis B		
	Influenza		
	Pneumococcal		Blood Pressure (Admin Use):
	Polio		
	Childhood Immunisations		

		Family Member	Extra Details (If any)
Family History	Diabetes		
	Asthma		
	Heart Disease		
	Mental Illness		
	Cancer		

Other Health Issues	Height:		Weight:		
	<input type="checkbox"/> Tobacco:	Day	Weekly	Monthly	Smoking Ceased (date):
	<input type="checkbox"/> Standard Alcohol Intake:	Day	Weekly	Monthly	Drug Use: Yes No
	Sun protection:	Always	Often	Sometimes	Rarely Never
	Females, when was your last -	Pap Smear:	Date:	Never	I Don't Know
	Males, when was your last -	Overall Check Up:	Date:	Never	I Don't Know
	<input type="checkbox"/> Advanced Health Directive		<input type="checkbox"/> Enduring Power of Attorney		
	For those over 65, when was the last time you were immunised against –				
	Influenza:	Date:	Never	I Don't Know	
	Pneumococcal pneumonia:	Date:	Never	I Don't Know	