Wellness MEDICINE

Please fill in this form, save it and email it to info@wellnessmedicine.com.au

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Adult Registration

Personal Details

A complete medical history is important for us to provide you with optimum health care. Please discuss anything you are unsure of with your doctor.

Title: _____ Surname: _____ First Name: _____

Date of Birth: ___/___/___ Marital Status : Please select

Address: _____ Suburb: _____

Phone Home: _____ Work: _____ Mobile: _____

Email: _____

Do you consent to receiving information about Wellness Medicine via email? Yes ◯ No ◯

Medicare Number: _ _ _ _ _ _ _ _ _ _ Expiry _ _/ _ _ PRN No. ___

Pension Number: _ _ _ _ _ _ _ _ _ _ Expiry _ _/ _ _ Aboriginal/Torres Strait Islander: Yes ◯ No ◯

Country of Birth_____

Emergency contact: _____ Contact Number: _____ Relationship: _____

Social/Life style

Current Occupation: _____or school _____ Year: _____

How did you hear about Wellness Medicine? _____

Do you live (circle) alone/ house share/ with family?

Smoker: Please select (___ per day) **Alcohol:** Please Select (how many drinks per week?)

Drugs: Please Select Is your diet: Please Select Dietary requirements?

Are you a vegetarian? Please select (If yes) do you eat dairy, eggs or fish?

Do you exercise regularly? Please select How many days a week do you exercise?

What type of exercise do you do?

Sign here to indicate that you are providing true and correct information, and that you have read and accepted our **Patient Privacy Policy** and **Cancellation Fee Policy.**

Signature patient/guardian: _____ **Date:** ___/___/___

Transfer of Health Information:

You may have consistently consulted with a GP at another practice. The health information held by the GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask receptionist for information about how this can take place.

Current Medications (including over the counter medication)

Name of medication	Strength	Times taken

Have you ever had any major operations or been admitted to hospital/ seen a specialist?

Year	Reason

Do you have any allergies to medicines or anything else? Please select

To what? Reaction?

Preventative Health

Have you ever had?

Problems	Year began	Active now	Serious Infection (circle)	Year began	Active now
Angina ☐			Skin rashes, dermatitis, eczema, psoriasis ☐		
High Blood Pressure ☐			Epilepsy/fits/blackouts / strokes ☐		
High cholesterol ☐			Migraine ☐		
Varicose veins, clots or blocked arteries ☐			Asthma/Emphysema ☐		
Stomach ulcers ☐			Hay fever/ sinus problems ☐		
Gall stones ☐			Eye/ ear problems ☐		
Liver disease, Jaundice, Hepatitis ☐			Back/neck problems ☐		
Pancreatitis ☐			Serious trauma ☐		
Hernia/ bowel problems ☐			Emotional disorder/ stress ☐		
Rectal bleeding ☐			Kidney/ urine/ bladder problems ☐		
Diabetes ☐			Prostate problems/ impotence ☐		
Thyroid problem ☐			Abnormal pap smear ☐		
Gout ☐			Sexually transmitted disease ☐		
Arthritis/ Joint problems ☐			AIDS ☐		
Cancer – where? ☐			Intravenous drug use ☐		

When was your last check for the following?

Medical History	Year
Cholesterol	
Blood Pressure	
Prostate Check	
Pap Smear	
Bowel Cancer	
HIV Test	
Hepatitis Test	

Immunisation:

Yes No

Did you have all your normal childhood vaccinations? ◯ ◯

Have you had a tetanus booster? Yes ◯ No ◯ when?

Have you had any additional vaccinations? E.g. for travel

If so what and when?

Immunisation:	Year	Immunisation:	Year
Tetanus		Chicken Pox	
Rubella		Influenza	
Hepatitis A		Pneumonia	
Hepatitis B		Measles	
Meningococcal		Cholera	
Typhoid			

Family History

Has anyone related to you ever had:(circle)	TYPE	Relationship to you	Ever had? yes/no	Age of onset	Died from yes/no	Age
High blood pressure ☐						
High cholesterol ☐						
Heart attack/angina ☐						
Stroke ☐						
Anaemia ☐						
Bleeding disorder ☐						
Asthma/ emphysema ☐						
Tuberculosis ☐						
Arthritis ☐						
Diabetes ☐						
Kidney disease ☐						
Cancer or tumour ☐						
Depression/anxiety ☐						
Mental Health disorder ☐						
Thyroid problems ☐						
Other ☐						