Wellness MEDICINE

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

41 Queens Parade
Clifton Hill VIC 3068
info@wellnessmedicine.com.au
P: 9489 7955 // F: 9489 7944

Child Registration

Child's 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: ____/____/____

Address: _____ Suburb: _____

Phone Home:_____ Work:_____ Mobile: _____

Email: _____

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

Medicare Number: __ __ __ __ __ __ __ __ __ __ Expiry __ __/ __ __ PRN No. ____

Aboriginal/Torres Strait Islander: YES ◯ NO ◯

Emergency contact/ Next of Kin: _____ Contact Number: _____

School _____ Year: _____

Previous Doctor: _____ Address: _____

Other family members attending this practice: _____ Any custody issues? _____

Medical History- (If appropriate)

Is your diet (circle): Poor / Fair / Good Please Select

(If vegetarian) do you eat dairy, eggs or fish? _____

Is your sleep (circle): Please Select

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

What type of exercise do you do? _____

Do you have any behavioural concerns?

_____

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 and Supplements (including over the counter medication)

Name of medication	Strength	Times taken

Has your child ever had any major operations or been admitted to hospital/ seen a specialist?

Year	Reason

Does your child have any allergies to medicines or anything else (circle)? NO YES

To what? Reaction?:

Pregnancy

Any problems in pregnancy? YES / NO

Born on time ? YES / NO

Mode of delivery: Please select

Any problems at birth? YES NO special care admission ☐ feeding problems ☐ jaundice ☐

Any physical abnormalities detected at any stage? YES NO Details?

Immunisation

Immunisation Please select

Did your child have all his/her normal childhood vaccinations? YES NO

Has your child had a tetanus booster? YES NO when?

Has your child had any additional vaccinations? E.g. for travel?

If so what and when?_____

	Year		Year		Year
Birth		**6 month**		**4 year**	
2 month		**12 month**		**Year 7**	
4 month		**18 month**		**Year 10**	

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:	TYPE	Relationship to you	Ever had ☑	Age of onset	Died from ☑	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			☐		☐	