AVALON FAMILY MEDICAL PRACTICE

REGISTRATION FORM

PATIENT INFORMATION

First Name	Surname	Date of Birth / /
Medicare No.	Position	Expiry	Occupation
Aboriginal or TSI Yes ◯ No ◯	Country of Birth	Sex - Male ◯ Female ◯ Other ◯
Concession Card No.	DVA Number	Marital Status
Address		
Home Phone	Mobile	Email

MEDICAL INFORMATION

Significant past illnesses (Please detail chronologically)

1. 3. 5.

2. 4. 6.

Family history of Illness (Please detail by family member)

Significant Operations (Please detail Chronologically)

1. 3.

2. 4.

Do you suffer from any of the following (please tick)

Joint / Muscle pain ◯	Shortness of breath ◯	Asthma ◯
Lethargy ◯	Anxiety/Depression ◯	Epilepsy ◯
Chest pain ◯	Heartburn ◯	Sleep Disturbance ◯

Medications past and present (including over the counter)

1. 4. 7.
2. 5. 8.
3. 6. 9.

ALLERGIES

1. Reaction
2. Reaction
3. Reaction

Do you currently, or have you ever smoked? Yes ◯ No ◯ Quit date _____ Tobacco / Other

Do you currently, or have you ever vaped? Yes ◯ No ◯ Quit date _____

Alcohol Consumption Yes ◯ No ◯ If yes how many days per week? How many standard units consumed?

Frequency of moderate physical activity per week 1 2 3 4 5 6 7

Frequency of vigorous physical activity per week 1 2 3 4 5 6 7

Have you had a cervical screen: Have you had a mammogram:

IN CASE OF EMERGENCY

Name	Relationship	Home phone no.	Mobile

Do you consent to the practice contacting you by SMS for health information and appointment reminders? Yes / No

Signature/Parent Guardian: Date: