Willowglen Medical Centre

5/837 Ruthven Street
Toowoomba Qld 4350
Ph 46709411 Fax 46709422
ACN 621 734 049 ABN 33 6217 34049

Accredited General Practice

Title ____ First Name: ____________ Middle Name: _______________Surname:

Date of Birth ___/___/_____ MALE / FEMALE (Please Circle)
Occupation:

Medicare Number: ____________________________ Individual Ref No: ________ Exp: ________

(Please Circle) Pension / Health Care Card Number: _________________________ Exp: ________

Veterans Affairs-DVA Number: ____ Exp: ________

Private Health- Yes / No – If YES Fund Name: ______________________________ Exp: ________

Country of Birth: ______________________________ Year of Arrival *(if applicable)* in Country: ________

Home Address: ____

Suburb: _________________________ Postcode: _________

Postal Address: ____

Suburb: _________________________ Postcode: _________

Phone: (H) ___________________ (W) __________________ (M) __________________

Email: ____

Would you like to receive
SMS / Email Reminders / Newsletters/ updates from our practice? YES /NO

If you are not registered for My Health Record would you like to do so? YES/NO
(If you wish to register for My Health Record, please provide us with 100 points of identification).

Are you of **Aboriginal** - Yes/No or **Torres Strait Islander Origin**? YES/NO

Do you identify with any Cultural Background? (Important to be answered) YES/NO
If 'YES' what is your ethnic background? _____________________

Do you require a translator or help with filling in this form? YES/NO

In case of an emergency, who is best to be contacted?

Name: ______________________________ Relationship to you: _________________________

Phone: (H) _________________ (W) _________________ (M) ________________

How did you hear about our clinic? TV, GOOGLE, FACEBOOK, FLYER, BY WORD OF MOUTH, HOTDOC

Willowglen Medical Centre follows the RACGP standards and guidelines. All information provided is treated strictly confidential. Willowglen Medical Centre participates in the National State & Territory Reminder System. I consent to the release of appropriate information to Specialists and Allied Health Professionals to facilitate my health care if needed. I consent to be contacted through mobile/home phone and letters. If I change contacts details it is my responsibility to inform Willowglen Medical Centre, so my records can be updated. I consent to assign my or as legal guardian my wards Bulk bill benefit to Willowglen Medical for each consultation with them. Some consultations do incur fees. Please ask at reception for a detailed list of any consultation fees. Some services which your doctor will discuss with you during your consultation e.g. Vaccinations/ Procedures /Pre-Employment Medicals/ Commercial Drivers License / Investigations could also incur an additional fee. * I consent for Willowglen Medical contact "Next of Kin" OR PERSON NAMED IF AN EMERGENCY SHOULD ARISE. (*Must reside in Australia)

WILLOWGLEN MEDICAL CENTRE NEW PATIENT HEALTH SUMMARY

Dear patient please fill this form to the best of your knowledge

Are you currently taking medication? YES/NO *If YES please list below:*

Do you have known **Allergies or Sensitivities**: YES/NO *If* YES *please state to what and any known reactions:*

Have you ever had or have now **Please write Y OR N- (Yes OR NO)**

High Blood Pressure	
Diabetes	
Asthma	
Shortness of Breath	
Heart Disease/Cardiomyopathy	
Epilepsy	
Arthritis	
Cancer	
Back Pain/Problems	
Parkinson's Disease	
Glaucoma	
Multiple Sclerosis	
Hypothyroidism	
Osteoarthritis	
Digestive Problems	
Bipolar/Mood Disorders	
Depression	
Schizophrenia	
Kidney/Renal Problems	
Eating Disorders	
Obesity	

Any other previous conditions illnesses Please specify:

____

Any Immediate Family History:

____

Smoker/ Ex-Smoker/ Non-Smoker (Circle) Start Date: _______________

How many per day? ____________ Cessation of smoking date: ________________

Do you drink alcohol (Circle)? YES/NO How many per day? ___________

How many days per week do you drink alcohol? ________

Female Questions:

Have you had a pap smear in the last 2 years: YES/NO Date:

Have you ever had a mammogram? YES/NO Date:

Signature of Patient / Parent / Guardian: ___________________ **Date**: _______