LAKESIDE SQUARE MEDICAL CENTRE

This complete medical history is important for you to obtain good health care. All information on this form will be treated as strictly confidential. Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down.

1. Personal Details

Full Name.. Preferred name...................................... D.O.B ..../......./........

Marital status: Single, Married, De Facto, Divorced (Please circle) Gender M / F

Street address.. Suburb...

Telephone (Home).. (Work)... (Mobile)..

Do you consent to receiving reminders and recalls via SMS Yes / No

Email.. Aboriginal/Torres Strait Islander Yes / No

Cultural Background………………………………………………………. Occupation...

Medicare number... PRN.......... Expiry ..../........

Pension/DVA number... Expiry ..../......../........

Emergency Contact Name...Relationship... Telephone....................................

Previous Doctor... Address...

Referred by……………………………………………………………………………

2. Medical History

Do you have any allergies to medicines or anything else? Yes / No

If yes, please state what you are allergic to and your reaction...

………

Have you ever had any operations? Yes / No Please list.. Year ....

………

Have you ever had or do you suffer from:

Problem	Y/N	Further details	Y/N	Problem	Y/N	Further Details
Heart Disease				Stroke / TIA		
Blood Pressure				Skin Rashes eg eczema, psoriasis		
High Cholesterol				Epilepsy		
Clots eg. thrombosis				Migraine		
Gastrointestinal Disorder				Asthma		
Liver Disease				Back Pain		
Diabetes				Cancer (where)		
Thyroid Ailments				Other conditions		
Kidney ailments						
Emotional disorders						
Arthritis						

Please turn over to complete registration form.

3. Social

Smoking History: ☐ Non Smoker ☐ Ex- Smoker ☐ Smoker Amount per day..............Year Started.............. Year Ceased.........

Alcohol: ☐ No ☐ Yes Days per week .... … Standard drinks per day ………

Exercise: ☐ No ☐ Yes Times per week.....................

Has any family members suffered from:

	Cancer	Heart disease	Diabetes	Other
Mother				
Father				
Siblings				

Current medications (medication, strength, dosage) ....

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………

Please return completed form to reception. Thank you