Cornwall Street
Medical Centre
BY UQ HEALTH CARE

New Patient Registration Form

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

Title	☐ Dr ☐ Prof ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master		
Surname		**Date of birth**	____ / ____ / _____
First name/s			
Birth sex	☐ Female ☐ Male ☐ Intersex	**Gender identity**	☐ Man ☐ Transgender man ☐ Woman ☐ Non-binary ☐ Transgender woman ☐ Other _____
Cultural background	Knowing your cultural background can help us provide healthcare that meets your individual needs. Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander **Other cultural background (e.g. Mediterranean, Asian. African):** _____ **Country of birth:** _____ **Is English your first language?** ☐ Yes ☐ No **If not, do you require an interpreter?** ☐ Yes ☐ No Please specify language: _____		
Occupation			
Street address			
Suburb		**Postcode:**	
Postal address	☐ Same as above		
Home phone		**Work phone**	
Mobile phone			
Email			
Medicare Card	__ __ __ __ __ __ __ __ __ __	**Ref no. :**	**Expiry date:** ___ / ___
Pensioner Card	__ __ __ __ __ __ __ __ __ __	**Expiry date:** ___ / ___ / ____	
Health Care Card	__ __ __ __ __ __ __ __ __ __	**Expiry date:** ___ / ___ / ____	
DVA Card	__ __ __ __ __ __ __ __ __ __	**Expiry date:** ___ / ___ / ____	
***OSHC/Student #** *Overseas Health Care		**Expiry date:** ___ / ___ / ____	
Next of kin	First Name: _____ Surname: _____ Phone: _____ Relationship to you: _____		
Emergency contact?	First Name: _____ Surname: _____ Phone: _____ Relationship to you: _____		

Recalls and reminders

Our practice uses a recall and reminder system to help you maintain your health. The practice sends recalls and reminders by **post**, **email**, **phone** or **SMS** for procedures such as vaccinations, cervical screening, skin checks and other health reviews.

Consent

From time to time we would like to contact you with health promotions to help you maintain your health.

Do you consent to receiving digital health promotions via email or SMS?

☐ Yes ☐ No

Our practice also sends information to the Australian Childhood Immunisation Register and National Cervical Cancer Screening Register. These registers also send reminders, which can be helpful if you move. **Please let your Doctor know if you wish to opt out.**

Signature of patient or guardian: _____ **Date:** ____ / ____ / _____

How did you hear about our clinic?

☐ Friend/family ☐ Princess Alexandra Hospital ☐ Social media ☐ Google ☐ Billboard / Shopping centre advert

☐ Newspaper / Magazine advert ☐ Street signage ☐ UQ ☐ OSHC

☐ Other: _____

Transfer of health information

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

Please advise us if your contact information or Medicare details change.

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Please give this page to your Doctor

Patient name: _____ Date of birth: ____ / ____ / ____

Please list your allergies and intolerances to medications if applicable	Describe your reaction

Please list your regular medications and doses, and complementary medications and doses

Medication	Dose (including how often taken)

Are you a smoker?

☐ Non-smoker ☐ Ex smoker ☐ Smoker

Amount per ☐ day ☐ week ☐ month: _____ OR date ceased smoking: _____

Do you drink alcohol?

☐ Never ☐ Occasionally ☐ Moderately ☐ Heavy

Days per week _____ Days per month _____ Standard drinks per occasion _____

Height and weight

Height (cm) _____ Current weight (kg) _____

Relevant past medical history

_____

_____

_____

_____

_____

_____

_____

Family medical history

Is your mother alive?

☐ Yes ☐ No ☐ Unknown

Age of death: _____ Cause of death: _____

Is your mother alive?

☐ Yes ☐ No ☐ Unknown

Age of death: _____ Cause of death: _____

Significant family history

Mother:

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression/mental ill health ☐ Breast cancer

Father:

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression/mental ill health