EVIDENCE BASED MEDICINE
EBM
FAMILY MEDICAL PRACTICE

Shop 1, 3 Coventry St
Mawson Lakes SA 5095
Phone: 8258 1115

Where did you hear about us? (please circle)					
Google	Newspaper	Friend/Family	Other Practice	Hospital	Other: _____

PATIENT DETAILS

Title (Mr, Mrs, Ms, Miss, etc)		Surname			
Given Names			Preferred Name		
Date of Birth	/ /		Gender	Male	Female
What is your Ethnicity (Please circle): *Australian, non-Indigenous *Aboriginal *Torres Strait Islander * Aboriginal & TSI *Other (Please Specify) _____					Are you a Refugee? Yes / No
Residential Address					
Suburb				State	Postcode
Postal Address (if different to above)					
Suburb				State	Postcode
Home Phone			Mobile		
Email				Consent to SMS Reminder? Yes/ No	
Medicare Number	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ IRN ___ Valid To _____ / _____				
Concession Number		Expiry Date	__/__/____	Type	
Dept. Veterans' Affairs Number				Class	
Private Healthcare Card (If No Medicare)		Expiry Date	__/__/___	Company	
Occupation				Student	Yes / No
Would you like to be added to our recall/reminder system?				Yes / No	

MEDICAL HISTORY

Usual/Previous Treating Doctor		Practice	
Allergies/ Adverse Drug Reactions	Yes / No	(If yes, please list item, reaction and severity)	
Current Medications			
Smoking Status	*(please circle)* Non-smoker Ex-smoker Smoker		
If current smoker	How many cigarettes per day:	Year started:	

PLEASE TURN OVER

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If ex-smoker	***(please circle)*** **Light** **Moderate** **Heavy** *Ex Smoker (please state)* Year started: Year stopped:			
Current Alcohol Intake	How many days per week:		Standard drinks consumed on any given day:	
Past Alcohol Intake	*(please circle)* Nil Occasional Moderate Heavy			
Mother Alive	Yes / No / Unknown	Age of Death:	Cause of Death:	
Father Alive	Yes / No / Unknown	Age of Death:	Cause of Death:	
Relevant Family History	***Please list any chronic health conditions:*** Mother: Grandparents: Father: Siblings:			
Personal Medical History *(please list or circle relevant information)*	Any recent Hospital Admissions and/or Operations/Procedures:			
	Chronic health conditions: Diabetes Heart Disease Cancer Stroke Asthma/Lung Issues Mental Health Issues Other: _____			
	Have you had any of the following removed: Appendix Gallbladder Tonsils/Adenoids Other: _____			
Immunisations *(please tick box if up to date & specify date administered if known)*	Tetanus ☐	Date ___/___/_____	Pneumococcal23 ☐	Date ___/___/_____
	Hepatitis A ☐	Date ___/___/_____	Hepatitis B ☐	Date ___/___/_____
	Whooping Cough ☐	Date ___/___/_____	Influenza ☐	Date ___/___/_____
For Females Only	Pap Smear	Date of last exam: ___ /___ /_____	Result: Negative / Positive	
	Hysterectomy	Yes / No	If yes, Date: ___ /___ /_____	
	Mammogram	Yes / No	If yes, Date: ___ /___ /_____	
For Children Only	Is the patient up to date for childhood immunisations? Yes / No			

NEXT OF KIN / EMERGENCY CONTACT			
First Name		Surname	
Address (if different to patient)			
Phone Number		Relationship	
Patient or Parent/ Guardian Signature		**Date**	

Please notify our Reception of any cancellations of appointments. *We ask for minimum one hour's notice prior to appointment cancellation or a fee will be charged for non-attendance.*