GAWLER GP Access AFTERHOURS

Shop 2, Murray Street, GAWLER, SA 5118
Phone: (08) 8522 3877
Fax: (08) 8522 3955

This form is to be completed by new patients

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

PATIENT DETAILS					
Title		Surname			
Given Names			Preferred Name		
Date of Birth	/ /		Gender	Male Female	
Do you identify as being of Aboriginal and/or Torres Strait Islander origin? No Yes, Aboriginal Yes, Torres Strait Islander Yes, Both				Are you a Refugee? Yes / No	
Residential Address					
Suburb			State	Postcode	
Postal Address					
Suburb			State	Postcode	
Home Phone		Mobile			
Email					
Medicare Number	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ IRN ___ Valid To _____ / _____				
Concession Number		Expiry Date	__/__/____	Type	
Dept. Veterans' Affairs Number			Class	GOLD	
Occupation				Student	Yes / No
Would you like to be added to our SMS APPOINTMENT reminders system?				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:	

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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		DOB: / /
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 at least one hours notice prior to appointment cancellation or a fee will be charged for non-attendance.