EMERALD MEDICAL CENTRE ST MARYS

65A Queen St, ST MARYS 2760

Tel: 02 98337211 Fax: 02 98337926 Email: emcstmarys@gmail.com

Title (Miss/Mrs/Ms/Mr)_____ Male/Female/other_____

First name_____

Last name_____

Date of birth_____ Known as/prefer to be called_____

Address_____

Postal address_____

Home Phone_____ Work Phone_____

Mobile_____ Do you accept SMS_____

Email address_____ @_____

Alternate contact persons

Next of Kin name_____ Relationship with you_____

Contact number_____

Emergency contact name if different from NOK_____

Relationship with you_____ Contact number_____

Marital Status_____ Occupation_____

Country of birth_____ Ethnicity/Cultural Background_____

Are you Aboriginal or Torres Strait islander? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

Languages spoken_____

Preferred language_____ Interpreter needed Yes / No

Do you have the following? If so please present to reception after completing this form

Medicare card _____ Veteran affairs card ☐ Private health insurance ☐

Centrelink pension / healthcare card ☐

For each consultation, I offer to assign my rights to Medicare, benefit payable to the doctors of Emerald Medical Centre St Marys who will render the medical services. I am aware of my rights to access my Medicare information from Emerald Medical Centre St Marys, which will be made available upon my request with adequate notification time. If the information is not readily available, I understand I will be given an explanation in these circumstances.

Signed_____ Date_____ / _____ / _____

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Health Interventions

Dietary

Do you suffer from any Allergies? Medications, dressings, food etc_____

If yes, please list what you're allergic to and nature of the reaction (e.g rash)_____

_____

We believe in the importance of a healthy diet. How well do you rate your current diet plan? (Please rate between 1 - 10)

_____

Please circle the correct option. Are you: Vegetarian Vegan Others: _____

Do you smoke?*(please circle)* Never Ex smoker, when did you quit?_____

Yes, for how long?_____How many cigarettes to you smoke a day?_____

Do you Drink Alcohol? *(Please circle)* Never / Monthly or less / 2-4 times a month / 2-3 a week / 4 or more times a week

How many standard drinks on a typical day? *(Please circle)* 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often do you have 6 or more drinks on one occasion? *(Please circle)*

Never Less than monthly Monthly Weekly Daily / almost daily

If you take any regular medication please write the name of medication and what it is for_____

_____

Do you have any ongoing health problems?_____

Do you have a **family history** of any of the following *(Please circle)*

Heart disease Yes / No If yes who?_____

High blood pressure Yes / No If yes who?_____

High cholesterol Yes / No If yes who?_____

Asthma Yes / No If yes who?_____

Mental illness Yes / No If yes who?_____

Cancer Yes / No If yes who and type?_____

Diabetes Yes / No If yes who and type?_____