STIRK MEDICAL GROUP

PATIENT DETAILS FORM

We are committed to providing our patients with the best care. It is essential that your health record is kept up to date and accurate. **Please complete all sections.**

Title:	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other: _____		
Surname:		**First Name:**	
Middle Name:		**Preferred Name:**	
Birth Sex:	☐ Male ☐ Female ☐Other	**Date of Birth:** / /	
Gender Identity:	☐ Male ☐ Female ☐ Trans ☐ Non-binary ☐ Other	**Pronouns:** ☐ he/him ☐ she/her ☐ they/them	
Ethnicity:		**Occupation:**	
Aboriginal or Torres Strait Islander	☐Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ No		
Street Address:		**Suburb:**	
Postcode:		**Postal Address:** *(if different from above)*	
Contact Number:	Home:	Work:	Mobile:
Email Address:			
Medicare Card Number:	_ _ _ _ / _ _ _ _ _ / _	**Ref No**. __ (in front of your name) **Expiry:**	
Pension/Health Care Card Number: ***(not private health)***	_____ ☐ Pension Card or ☐ Health Care Card	Expiry:	
DVA Number :	_____Gold / White *(please circle)*	Expiry:	
Emergency Contact or Next of Kin:	First Name: Last Name: Contact Number: Relationship:		

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HEALTH SUMMARY/HISTORY

Do you have/had in the past any of the following?	☐ Diabetes ☐ Asthma ☐ Hypertension ☐ Chronic Illness ☐ Operations ☐ Other (Please state): _____ _____
Family history:	☐ Diabetes ☐ Asthma ☐ Cancer ☐ Mental Illness ☐ Heart Disease ☐ Other (Please state): _____ _____

Do you have any ALLERGIES? ☐ Yes (Please specify) _____ ☐ No

What type of reaction do you have? _____

Are you sensitive to any drugs or dressings? ☐ Yes (Please specify) _____ ☐ No

Immunisations – Have you had the following?	Influenza ____/____/____	Unsure	No
	Tetanus booster ____/____/____	Unsure	No
	Pneumococcal ____/____/____	Unsure	No
	Polio ____/____/____	Unsure	No

If completing form for a child, are immunisations up to date? Yes / No

Over 65s:	**When was the last time you were immunised?**		
	Influenza ____/____/____	Unsure	Haven't Had
	Pneumococcal pneumonia ____/____/____	Unsure	Haven't Had

Current medications:	**Please list:** _____ _____ _____ _____ _____
Lifestyle history:	Smoking: ☐ No ☐ Yes - How many ___ Day ___Week Alcohol: ☐ No ☐ Yes - How many ___ Day ___Week Recreational drug use: ☐ No ☐ Yes - Type_____ Frequency_____

Reminder System Our practice provides our patients with preventative and early detection reminders e.g Immunisations, Annual Health Checks, Skin Checks and Pap Smears.

ALL ACCOUNTS ARE THE RESPONSIBILTY OF THE PATIENT. Once payment has been made in full, we will send your account to Medicare for your refund to go to your nominated account. **I am aware there may be a gap.**

Patient signature: _____ Date: _____

How did you hear about us? ☐ Flyer ☐ Signage ☐ Recommended ☐ Online /Website ☐ Live in area ☐ Other: _____