We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

|  |  |
| --- | --- |
| **Title (Mrs, Mr, etc)** |  |
| **First Name** |  |
| **Surname** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Home Phone** |  |
| **Mobile Phone** |  |
| **Email** |  |
| **Medicare Number** |  | **REF:** | **Expiry Date:** |
| **Concession/Pension Card Number** |  | **Expiry Date:** |
| **Are you Aboriginal or Torres Strait Islander** | **No ****Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander ** |
| **Marital Status** | **Single  Married Defacto Separated Divorced  Widowed ** |
| **Occupation** |  |  |  |
| **Ethnicity/Nationality** |  |  |  |
| **Country of Birth** |  |  |  |
| **Next of Kin/Emergency contact** | **Relationship:** | **Name:** | **Phone Number:** |
| **Allergies** | **YES/NO** (Circle) | **Please List:** |
| **Do you smoke?** | **YES/NO** | **If so, how many a day?** |
| **Do you consume Alcohol?** | **YES/NO** | **If so, how many glasses a day?** |
| **Measurements** | **Height in cms:** | **Weight in kgs:** |
| **Medical History**(Please list any current/previous history of disease.) |  |
| **Family and past history**(please list any past history of disease in your family.) |  |
| **For female Obstetric History** | When was your last pap smear? |

**I agree to allow Barrymore Medical Centre to collect information relevant to medical care and treatment from the doctors. I consent to the use of my mobile number for SMS to contact me for reminders and recalls.**

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_