FIRST PEOPLES'
HEALTH AND WELLBEING

please return this form to
thomastown@fphw.org.au or frankston@fphw.org.au
or hand to our friendly reception team

First Peoples' Health and Wellbeing

New patient form

To become a patient at First Peoples' Health and Wellbeing, we require your agreement for us to collect personal information. This is to make sure we can provide you with quality health care. We need you to provide this information so that we can properly assess, diagnose and treat your health conditions, as well as be aware of your possible health risks.

First Peoples' Health and Wellbeing will always look after your personal information in a way that protects your privacy and adheres to the National Privacy Principles and the Victorian Health Records Act. You may request a copy of our privacy policy at any time.

Please read this carefully, tick the boxes and sign below, or speak to one of our health clinic team.

☐ I give my permission for my personal health information to:

be used to assist in the running of First Peoples' Health and Wellbeing
be shared when required with relevant individuals involved in my healthcare
be used in a way that does not personally identify me in reports for organisations that provide funding to First Peoples' Health and Wellbeing
contact me about my health and remind me about appointments
comply with any laws or regulation requirements e.g. notifiable diseases
be added to national and state reminder systems including cancer screening and immunisations

OR

☐ I am unsure and would like to speak to someone in the health clinic

Signed: _____ Date _____

First Peoples' Health and Wellbeing

New patient form | confidential

Your details

First name | Middle name | Last name

Date of Birth | Age | Preferred name

Sex ○ Female ○ Male ○ Intersex

Gender ○ Female ○ Male ○ Other

Are you: ○ Aboriginal ○ Torres Strait Islander ○ Aboriginal **and** Torres Strait Islander

○ Non-Indigenous

Who's your mob?

Card details

Name on Medicare card

Medicare number | Ref | Expiry

Pensioner / Health Care Card | Ref | Expiry

number DVA card number | White ☐ Gold ☐ | Expiry

Do you have ambulance cover? Yes ☐ No ☐

Did you opt-out of MyHealthRecord? Yes ☐ No ☐

Contact details - please update us if you change any of these details

Home Address

Mailing address

Mobile number

Home number

Work number

Email address

Communication consent

☐ Agree to receive SMS messages about appointments

☐ Agree to receive SMS messages about news and events

☐ Agree to receive email newsletter

Emergency contact details

I understand it is my responsibility to update First Peoples' Health and Wellbeing with my correct contact details

Next of kin contact name

Next of kin contact number

Next of kin relationship to you

Emergency contact name

Emergency contact number

Emergency contact relationship to you

How people live in your house?

Do you currently work? Yes ☐ No ☐

Do you have a carer? Yes ☐ No ☐

Are you a carer? Yes ☐ No ☐

Do you have any pets? Yes ☐ No ☐ How many?

Medical records

Do you require your medical records to be transferred from another clinic? ☐

Doctors name

Name of clinic

Town of clinic

Previous medical history

Do you have, or have had, any of the following:

Arthritis	☐		Breathing problems	☐	
Cancer	☐		Chronic pain	☐	
Diabetes	☐		Heart problems	☐	
High blood pressure	☐		High cholesterol	☐	
Kidney problems	☐		Liver problems	☐	
Low blood pressure	☐		Men's business problems	☐	
Mental health conditions	☐		Women's business problems	☐	

Other (please list)

Current medications

Which medications do you take currently? Include over-the-counter and natural medicines

Recent trips to hospital

What for

Year | Which hospital

What for

Year | Which hospital

What for

Year | Which hospital

Other health information

Allergies

Do you have any allergies or sensitivities? Yes ☐ No ☐

To what? | What happens?

To what? | What happens?

To what? | What happens?

To what? | What happens?

To what? | What happens?

Family medical history

Please let us know the medical history of your close family members and who in your family has/had these conditions

Alcohol

How often do you drink alcohol?

Never ◯ Monthly or less ◯ 2 to 4 times a month ◯ 2 to 3 times a week ◯ 4 or more times a week ◯

When you have a drink, how many do you usually have in one day?

N/A ◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more ◯

How often do you have six more drinks in one day?

Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily ◯

Smoking

Current smoker ◯ Ex-smoker ◯ Never smoked ◯

How old were you when you started smoking? _____ Number of cigarettes per day? _____

When did you quit smoking? _____ Do you smoke yarndi? ☐

Are you interested in quitting smoking? _____

Measurements

Height _____ Weight _____ Waist measurement _____

Physical activity

How many days a week do you do 30 minutes or more of moderate activity that makes you breath harder than normal?

Zero ◯ 1 or 2 ◯ 3 or 4 ◯ 5 or more ◯

Women's business

When was your last pap smear / cervical screening? _____

When was your last mammogram / breast screen? _____

Have you had any problems related to menstruation or menopause? _____

Any complications with pregnancy or childbirth? _____

I believe this is an accurate and true record of my current health situation

Signature _____

Name: _____

Relationship Self ◯ Partner ◯ Carer ◯ Other _____