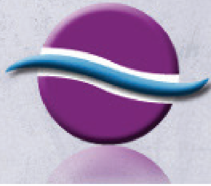

KEPERRA
FAMILY PRACTICE & SKIN CANCER CLINIC
Let our family care for your family!

Welcome to Keperra Family Practice & Skin Cancer Clinic.

You can save time on the day by completing both forms prior to your visit. Please hand this form to a receptionist when you arrive for your appointment and the Personal Medication form to your doctor.

New Patient Information & Practice Registration

Title: ……………..…. **Full Name:**……………………………………………………………….………

Known As: ……………………………………….…………… **D.O.B :** …………………………..…..

Home Address: ………………………………...………………………………………………..

…………………………………………………..………………………………………

Phone: (Home)…………………………**(Work)**……………………**(Mobile)** ………………………………

Email: ……………………………………………………………………………………………………
(To send you reminder letters, practice information etc)

Medicare Card No:……………………………..……….……. **Ref No:**……. **Expiry Date**…..../..…/……..

Centrelink Concession No :…………….……..…………………………… **Expiry Date**…..../..…/……..

Department of Veteran Affairs:

White Card:…………………………..………. Gold Card: ………………………….……………

Private Health Membership……………………………..**Member No**………………………………..…

Employer Details: ……………………………………………………………………………..…

……………………………………………………………………………………..

Partner's Name : …………………………………………… **Phone:**……………………………………….

Next of Kin : ……………………………………………… **Phone:**……………………….……………
(if partner not available)

Country of Birth:……………………………………………….

Language spoken:…………………………………………..

Do you require and interpreter: ☐ **Yes** ☐ **No**

Please tick:

☐ **Are you Aboriginal?**
☐ **TSI**
☐ **Aboriginal and Torres Strait Islander**
☐ **Non-indigenous**

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Personal Medical Information.

Please hand this form to the Doctor at the time of your consultation.

Past illnesses: Please include all significant problems:

Diabetes : ☐ Yes ☐ No ☐ Type 1 or ☐ Type 2

Heart Disease: If Yes, please give details below

……

……

……

Any other Significant illness:

……

……

Operations : Please include all surgery and approximate dates

……

……

……

Current medications: Tablets etc: please include over the counter medications and vitamins etc:

……

……

……

Allergies ……………………………………………………

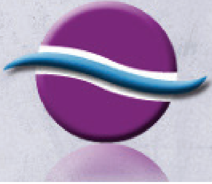
……………………………………………………

Female Patients

Have you had a Pap smear? ☐ Yes ☐ No

If yes, date of last Pap smear ……………………………………………

Great Western Super Centre, Cnr Settlement & Samford Rds, Keperra > PO Box 2155, Keperra, Brisbane Q 4054
Phone: (07) 3351 0323 > Fax: (07) 3851 4508 > www.keperrafamilypractice.com.au



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All Patients to complete this section

Family History: please list all known significant problems in your family including Diabetes or Heart Disease.

Father:………

Mother: ……

Brothers & Sisters: ……………………………………………………………………………………………

Grandparents: …………………………………………………………………………………………………
(Please use reverse of this form if you need more space)

Do you smoke? ☐ Yes ☐ No **if yes, how many per day?** …………………..

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per day on average? ……………………………………………….

If the new patient is a child:
Are all childhood immunisations up to date? ☐ Yes ☐ No ☐ Unsure
If unsure please speak with Doctor.
Please list any immunisations you have had……………………………………………………………..

……

Adult Patients:
When did you last have a Tetanus vaccination?……………………………………………………

Do you have an annual Flu vaccination?…………………………………………………………………

Do you have a 5 yearly Pneumovax vaccination? (Free to over 65's)………………………..

When was your last skin check?………………………………………………………………………

Please feel free to write down any questions you may have for the Doctor.

……

……

……

……