Registration Form

WOMEN'S
HEALTH HUB

PERSONAL DETAILS

Title:__________ First Name:______________________________

Surname:______________________ D.O.B.______/______/______

Address:____

Suburb:________________________ Postcode:______________

Tel: H:________________________ M:____________________

Email:____

Occupation:_________________ Marital Status:____________

Country of Birth:______________________________________

Language Spoken:______________________________________

Are you of Aboriginal or Torres Strait Islander descent?
Yes No

MEDICARE DETAILS

Medicare Number:______________________________________

Reference Number (in front of name:)_____ Expiry Date:______/______

Pension/Centrelink Card Number:________________________

Expiry Date:______/______/______

If DVA, which: ORANGE WHITE GOLD

DVA Number________________________ Exp______________

ALLERGIES

Do you have any allergies or sensitivities? YES / NIL KNOWN

Name of Drug/Ingredient/Product_________________________
If YES, Type of Reaction: Mild/ Moderate/ Severe

Name of Drug/Ingredient/Product_________________________
If YES, Type of Reaction: Mild/ Moderate/ Severe

EMERGENCY CONTACT

Name:____

Relationship:____________________ Tel:__________________

Next of Kin (if different from above)_____________________

Relationship:____________________ Tel:__________________

HOW DID YOU HEAR ABOUT US?

Word of Mouth ☐ Flyer/Mailbox ☐ Newspaper ☐

Facebook ☐ Hoppers Lane GP ☐ Family ☐

Internet ☐ Passing By ☐ Werribee Hospital ☐

Other (please specify)___________________________________

FAMILY HISTORY

Has any member of your family been diagnosed with diabetes, a heart condition or any form of cancer? If yes please detail:

____

____

Mother Alive? Yes No Age of Death?________ Cause of Death?________

Father Alive? Yes No Age of Death?________ Cause of Death?________

Any Other Family History?_______________________________

PAST MEDICAL HISTORY

Have you ever been a patient in a hospital, if so for what reason and in which year? _________________________

____

Are you a diabetic? YES NO If yes, Type 1 OR Type 2

When was your last Pap smear / Cervical Screening (Women Only)? ______________

Do you suffer from high blood pressure? YES NO

Have you ever suffered from chest pain or shortness of breath?
YES NO

SOCIAL HISTORY

Do you smoke? YES NO
If YES, how many per day:_______________________________

Have you previously smoked? YES NO
If YES, when did you give up smoking?_____________________

Do you drink alcohol? YES NO
If YES, how many days per week:__________________________

Privacy Agreement & Patient Consent: I understand that Women's Health Hub and associated Medical Centres comply with the Privacy Act (1988) and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Women's Health Hub collecting, using, storing and disposing of my personal information; the release of relevant personal information to relevant health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits; inclusion in national /state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdrawal my consent for Women's Health Hub to use and disclose my personal information (except where legal obligations must be met).

SIGNATURE:_______________________________________

DATE:____

HEALTH ASSESSMENT / CARE PLANS

You may be eligible for a care plan or health assessment, please speak to our friendly staff.