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

☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

CULTURAL BACKGROUND

Ethnicity:_____ Language Spoken:_____

Are you of Aboriginal or Torres Strait Islander descent?

No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐
Yes, Both Aboriginal and Torres Strait Islander ☐

MEDICARE DETAILS

Medicare Number:_____

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

Pension or Concession 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 ☐ Heart Condition ☐ 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?_____

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 drinks per day:_____

If YES, how many days per week:_____

Height:_____ Weight_____

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

END OF LIFE CARE

Do you have an advance health directive for end of life care?

Yes ☐ No ☐

For more information talk to your GP.

If you are suffering any chest pain, shortness of breath or need urgent medical attention, please notify reception immediately.

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. Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers are also send reminders, which can be helpful if you move. 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). I consent to receive the following electronic reminders/messages: Appointment, clinical communication, clinical reminders and health awareness

SIGNATURE:_____

DATE:_____

HEALTH ASSESSMENT / CARE PLANS

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