 **Eatons Hill Medical Centre**

**Patient Registration Form – Iron Infusion**

**PATIENT DETAILS**

Mr  Mrs  Ms  Miss Other

**Surname:**

|  |
| --- |
|  |

**Given Names:**

|  |
| --- |
|  |

**Preferred Name:**

|  |
| --- |
|  |

**DOB: \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_**

**Medicare Number:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  | Ref no: |  |

Expiry date: / /

Are you of Aboriginal or Torres Strait Islander Australian origin?

No  Aboriginal  Torres Strait Islander

**Address::**

|  |
| --- |
|  |
|  |
|  |
| Phone (Home) |
| Phone (Work) |
| Phone (Mobile) |

**Pension / Health Care Card no:**

|  |  |
| --- | --- |
|  | Expiry: / |

**Vet Affairs Number:**

|  |  |
| --- | --- |
|  | Expiry: / |

**Emergency Contact Person:**

|  |
| --- |
|  |
| Relationship to Patient: |
| Phone: |

**Next of Kin: *Same as Emergency Contact***

|  |
| --- |
|  |
| Relationship to Patient: |
| Phone: |

**Notice of Privacy Practices: Acknowledgement**

Eatons Hill Medical Centre keeps a records of the health care services provided to you. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes or compels us to do so. By signing below, you will be acknowledging that you have understood our Privacy Practices.

This signed form will also be retained in your medical records and will remain effective until revoked by you in writing.

**Additionally**: *May we leave a message on the phone numbers that you have provided: that states who we are, where we are from and confirm or cancel your appointment.*  **YES / NO**

**Do you consent to Eatons Hill Medical Centre doctor downloading your blood test results from the relevant pathology company ready for your appointment? Yes / No**

Circle: QML S&N Other \_\_\_\_\_\_\_\_\_\_\_

***I have read and understand the Policy and consent:***

*Signature:*

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Relationship ( if parent or guardian): \_\_\_\_*\_\_\_\_\_\_\_\_\_\_

*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*Do you consent to have an email reminder for your appointment if it is available*: **Yes / No**

**Cancellation and/or No Show Policy**

**Appointments that are cancelled without at least 3 hours’ notice or where the patient does not show up or does not call to cancel until after the appointment time will be billed to the patient according to the appointment.**

|  |
| --- |
| **Regular GP:** |
| **Practice:** |
| **Phone No:** |

**IRON INFUSION:** Have you had an iron infusion before? Yes  No

If YES, have you had any reactions and what were they? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Why has your doctor recommend an iron infusion? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL INFORMATION** *(if not enough space, complete at end or on additional page)*

**Past Medical & Surgical History**

Do you suffer from, or are you affected, by any of the following?

Diabetes  Asthma  Heart Condition  Chronic Illness  Hypertension  Cancer

**Do you suffer from any liver dysfunction or liver disease?**  Yes  No

Other Medical History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical Operations**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications** (including over the counter medication, vitamins and minerals): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies and/or Sensitive to Any Drugs or Dressings/Tapes**? No  Yes  (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social and Lifestyle History**

**Alcohol**: *How often do you have a drink containing alcohol*?

**Never**  Monthly or Less  2-4 times per month  2-4 times per week  4+times per week

*How many standard drinks containing alcohol would you have on a typical day?*

1-2 Drinks  3-4 Drinks  5-6 Drinks  7-9 Drinks  10+Drinks

*How often would you consume 6 or more drinks on one occasion?*

Never  Monthly  Less than monthly  Weekly  Daily or almost daily

**Tobacco**:  **I have never smoked**  Ceased Smoking \_\_\_\_\_ (year)  Smoker .….. per day/week

**Female Health**: When did you last have?

Cervical Screening (Pap smear) Date: \_\_\_\_\_\_\_\_\_\_\_  Not sure  Never

Breast Check Date: \_\_\_\_\_\_\_\_\_\_\_  Not sure  Never

Mammogram Date: \_\_\_\_\_\_\_\_\_\_\_  Not sure  Never

Are you pregnant or planning a pregnancy?  Yes  No

Are you breastfeeding? Yes  No

**Family History**: Please list any family members who have been diagnosed with any of the following: ie mother

Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer (please state type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunisations:** (if possible, please provide a record of your current immunisation status).

Flu vaccine - Year: \_\_\_\_\_\_\_ Tetanus vaccine - Year: \_\_\_\_\_\_\_

Whooping Cough vaccine - Year: \_\_\_\_\_\_\_ Measles vaccine - Year: \_\_\_\_\_\_\_