



info@bridginghealth.com.au | P 02 6100 3011 | F 02 6161 8797

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

## SECTION A: PERSONAL DETAILS

Title		Surname		Given Names			
Preferred Name			Date of Birth		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Non-Binary		
Address						City/Suburb	
Postcode		<input type="checkbox"/> Mobile		<input type="checkbox"/> Home		<input type="checkbox"/> Work	
Email				Occupation			
<b>Medicare Card Number</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/>				<b>Pension Card Type/Number</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
<b>Expiry</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				<b>Expiry</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Type?</b>			

NEXT OF KIN

Name		Relationship	
Best Contact Number: <div> <input type="checkbox"/> Mobile         </div> <div> <input type="checkbox"/> Home         </div> <div> <input type="checkbox"/> Work         </div>		<input type="checkbox"/> This person is also my emergency contact.	

## WHO CAN WE CONTACT IN AN EMERGENCY?

Name		Relationship	
Best Contact Number:	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work		

**Do you have an advance care directive for end of life care?** ☐ Yes ☐ No ☐ I would like more information about this.

**Do you want us to upload relevant information to your MyHealth Record?**

☐ Yes – with my consent. ☐ No ☐ I would like more information about this.

**Do you want us to upload any vaccinations you receive to the Australian Immunisation Register?**

☐ Yes – with my consent. ☐ No ☐ I would like more information about this.

**How did you hear about us?**

☐ Google ☐ Facebook ☐ Pharmacy Staff ☐ Friend/Family ☐ Friend/Family ☐ Signage  
☐ Other

**- Please Complete Other Side of this Form -**

## SECTION B: CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Prefer not to say

Other cultural background (e.g. Mediterranean, Asian, African)		Country of Birth
Is English your first language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Language(s) spoken at home:
Do you require an interpreter?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

## SECTION C: ALLERGIES AND MEDICINES

List any allergies to medicines or intolerances that you have:	Describe your reaction:
<input type="checkbox"/> I have no known allergies to medicines.	
List any regular medicines you take, along with doses (if known). Include herbal or vitamin products.	
<input type="checkbox"/> I do not take any regular medicines.	

## SECTION D: MEDICAL HISTORY

Please tick any relevant *personal* past medical/surgical history.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Migraines                  | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Blood Clots                | <input type="checkbox"/> Mental Health Issue |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Asthma, COPD or Emphysaema |  |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Acid Reflux                |  |

## SECTION E: LIFESTYLE HISTORY

Smoking:

☐ Never smoked ☐ Former smoker (quit date)\_\_\_\_\_ ☐ Smoker\_\_\_\_\_/day; started what year?\_\_\_\_\_

Alcohol:

☐ Non-drinker ☐ Drinker

Average Number of Days/Week you have a drink\_\_\_\_\_ Average Number of Drinks/Occasion\_\_\_\_\_

## SECTION F: CONSENT

Bridging Healthcare uses a reminder system to help you maintain your health. The clinic sends reminders by email, post or SMS for reminder procedures like vaccinations and other health reviews you need. By signing below, you consent to being contacted for reminders relating to the planning and managing of your health. By signing below, you consent to your de-identified health information to be shared for the purposes of service improvement and research activities that provide insight into and improve community health and health services management.

Patient Name (Printed)\_\_\_\_\_ Signature\_\_\_\_\_ Date\_\_\_\_\_