FTMC GROUP
P. 02 6555 0444
F. 02 6554 7200
office@ftmc.com.au
ftmc.com.au

Patient Information Form

Patient Details:

Title: [Mr./Mast./Mrs./Ms./Miss./Dr.]

First Name: _____

Middle Name: _____

Last Name: _____

Preferred Name (if applicable): _____

Date of Birth: _____

Birth Sex: [Male Female Other]

Gender Identity: [Male Female Non-Binary Transgender Other]

Pronouns: [He/Him She/Her They/Them/Other]

What is your preferred language:

_____

Contact Information:

Home Address: _____

Postal Address: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Healthcare information:

Medicare Card Number: _____ IRN: EXP: _____

Pension/Health Care Card Number (if applicable): _____ EXP:_____

DVA (Department of Veterans' Affairs) Number (if applicable): _____

Emergency Contacts: Who can we call in an emergency?

Next of Kin:

Name: _____

Relationship: _____

Phone: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

Additional Information:

Occupation: _____ If retired, from what? _____

Allergies: _____

Smoking History: Do you smoke? How many a day? Year started?

_____

Alcohol History: Do you drink? How many per day? Days per week?

_____

What is your relationship status:

- ☐ Single
- ☐ Married
- ☐ De Facto
- ☐ Separated
- ☐ Married
- ☐ Divorced
- ☐ Widowed

What is your sexuality:

- ☐ Heterosexual
- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Pansexual

Are you an elite athlete? YES/NO

If yes, which sport? _____

Do you have a history of:

Operations: _____

Asthma:

_____

Diabetes: _____

Hypertension: _____

Chronic Illness: _____

Other (please list):

_____

_____

_____

_____

Have you had a cervical screen (pap smear)? _____

Have you had a mammogram? _____

Have you had a prostate check?_____

Family history and Social history: (For your GP)

Is your mother alive? YES/NO Cause of death: _____ Age at death: _____

Is your father alive? YES/NO Cause of death: _____ Age at death: _____

Any significant family medical history?

Ie: Stroke, diabetes, heart attack, depression, any cancers, etc (Please specify)

_____

_____

_____

_____

Do you drink alcohol? YES/NO If yes, how many drinks per day ____ how many days per week ____

Do you smoke? YES/NO If yes, how many per day ____ What year did you start? _____

Are you currently breastfeeding? YES/NO

What is your country of birth?

_____

Ethnicity:

Please select your ethnicity: (Cultural background)

- ☐ Australian, non-indigenous
- ☐ Aboriginal but not Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Torres Strait Islander but not Aboriginal
- ☐ Other (please specify): _____

Consent and Agreement:

I understand that the information provided above will be used to ensure the quality of healthcare services and accreditation purposes. I consent to the collection, storage, and use of this information

by the healthcare facility and its authorized personnel. I acknowledge that I have the right to update or correct my information at any time.

Patient Signature: Date: _____

Note: Your privacy is important to us. This information will be kept confidential and will be used solely for healthcare and accreditation purposes. If you have any concerns about providing certain information, please discuss them with our staff.

***** IF THE PATIENT UNDER 18 AND IS ON A PARENT/GUARDIAN MEDICARE CARD PLEASE FILL OUT THE FOLLOWING: *****

Parent/Guardian name: _____

Medicare reference number: _____

DOB: _____

Relationship: _____

Phone: _____

Address if different to patient: _____

Forster Tuncurry Medical Centre
14-16 South Street, Forster

South Street Medical Centre
Suite 4, 10-12 South Street, Forster

Macintosh Medical Centre
97-99 Macintosh Street, Forster

Pacific Palms Medical Centre
208 Boomerang Drive, Blueys Beach

Tuncurry Village Medical Centre
Shop 1, 27-29 Manning Street, Tuncurry