

Patient’s Surname: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AS IT APPEARS ON MEDICARE CARD. PLEASE ADVISE ANY ALTERNATIVE SURNAME.

**Patient’s Given Names:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Male □ Female

**Residential Address:** ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­ Postcode: \_\_\_\_\_\_\_\_\_­­­

**Postal Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_

**Date of birth**: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Parent / Guardian’s details and contact information**

Name­­­­; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give consent to receive a SMS to confirm appointments: **□ Yes □ No**

**Parent 1 details Parent 2 details**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_ D.O. B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR MEDICARE PURPOSES FOR MEDICARE PURPOSES

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is responsible for the account?**

Mr / Mrs / Miss / Ms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *First Name Surname*

**Relationship to child:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I accept full responsibility for payment of accounts: -*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Signature***

**Medicare No.** \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ **Ref No.** \_\_\_\_\_ **Expiry Date** \_\_\_\_/\_\_\_\_\_\_

 **(NUMBER NEXT TO PATIENTS NAME)**

**Parents Medicare Ref Number – Mum:** \_\_\_\_\_\_\_ **Dad:** \_\_\_\_\_\_\_

**Pension No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiry Date** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Health Care Card No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiry Date**\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Name and Clinic of usual GP:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and Clinic Referring Doctor :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Alternative Contact****:*

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

*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Is the patient Aboriginal or Torres Strait Islander origin?***

***□*** *Aboriginal □ Torres Strait Islander □ Both □ No* *□ Do not wish to disclose*

***Are there any custody restrictions applicable to this child? □ YES □ NO***

***If yes, please discuss this with the Paediatrician.***

**MEDICATIONS – Please list** – (*including pills, syrups, lotions or herbal remedies*)

………………………………………………………………..……………………………………...……..…

………………………………………………………………..…………………………………….…..….….

**OTHER CHILDREN (brothers, sisters or other children who live in the household)**

Name Date of Birth Name Date of Birth

………………..………………… ……/……/…... ………………..………………… ……/……/…....

………………..………………… ……/……/…... ………………..………………… ……/……/…....

………………..………………… ……/……/…... ………………..………………… ……/……/…....

Does your child suffer from any allergies or bad reactions to drugs or treatments, etc? If yes please give details ………………………………………………………………………………………….…..….…

……………………………………………………………………………………………….…….….

**MOTHER’S PREGNANCY:**

Were you well during pregnancy? (*flu colds, operations, accidents*)……………………………………

Did you smoke during your pregnancy? □ YES □ NO. Drink alcohol? □ YES □ NO

Did you take any medicine during the pregnancy?…………………………………..……………………

Was there any bleeding or fluid loss before the delivery? If so, when?…….….……………………….

Did you have any ultrasounds or Xrays? If so, when and result(s)? Ultrasound..………….………….……………… Xray……………………….……………………….

Have there been any miscarriage/still births? ……………………..………………….….……………….

**BIRTH:**

How long was the labour?…………..……….….. Did labour start naturally? …………..………………

Was baby born early, late or on time? (*eg 3 weeks early*)……………………………………………..…

Was any help necessary with forceps, vacuum or was a Caesarean performed?….…………………

What was the baby’s birth weight?………………………….

Did baby’s condition at the birth cause any concern?……………………………………….……………

Did he/she cry normally?………………………………………………………………….……...………..…

Did he/she stay in special care nursery for any reason?…………………………………………….……

Is there any family history of fits, slow development, any serious family illness or anyone in the family with problems like your child? ………………………………………………………………………

………………………………………………………………………………………………………………….

DEVELOPMENT – (for children currently under 6 years of age)

How old was your child when he/she:

Smiled…….………………….Sat unsupported……..….………Said first word……….………..……...

Crawled………………………Walked unaided…….……….…..Fed him/herself…….…..…………….

Has your child lost the ability to do any tasks that he/she could formally do? □ YES □ NO

**IMMUNISATION**

Is your child fully immunised? □ YES □ NO

Details………………………………………………………………………….………………………….….

OTHER MEDICAL ILLNESSES, OR HOSPITAL ADMISSIONS, OR OPERATIONS:

Details…………………………………………………………………………………………………………