LAKESIDE SQUARE MEDICAL CENTRE
New patient form (child)

This complete medical history is important for you to obtain good health care. All information on this form will be treated as strictly confidential. Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down.

1. Personal Details

Full Name..... Preferred name..... D.O.B...../...../.....

Gender M / F

Street address..... Suburb.....

Telephone (Home)..... (Work)..... (Mobile).....

Aboriginal/Torres Strait Islander Yes / No

Cultural Background……..

Medicare number..... PRN..... Expiry ...../.....

Health Care number..... Expiry ...../...../.....

Emergency Contact Name.....Relationship..... Telephone.....

Previous Doctor..... Address.....

How did you hear about us?.....

Was your child referred to this practice by the Maternal Child Health Nurse? ☐ YES ☐ NO

2. Medical History

Does your child have any allergies to medicines or anything else? Yes / No

If yes, please state what your child is allergic to and their reaction.....

Current medications (medication, strength, dosage) ....

....

....

Does your child have or had a history of?

☐ OPERATIONS

……

☐ ASTHMA ……

☐ ANY OTHER ILLNESS……

Are your childs immunisations up to date? ☐ YES ☐ NO

Family history- Have any members of your family had?

Diabetes……..Asthma……

Heart disease…….Mental Illness……..

Cancer……