

# Medical History Form

[www.drugstore.com.au](http://www.drugstore.com.au)  
[www.chemistaustralia.com.au](http://www.chemistaustralia.com.au)

**\*\*PLEASE PRINT CLEARLY IN BOLD CAPITAL LETTERS\*\***

Order Number (first Five digits): \_\_\_\_\_ Gender: Male / Female \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_

State: \_\_\_\_\_ Post Code: \_\_\_\_\_ Home PH: \_\_\_\_\_ Mobile: \_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_

Other Over-the-Counter Medicines: \_\_\_\_\_

Current Medical Conditions: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

If Applicable:

Medicare number (10 digits): \_ \_ \_ \_ \_ Patient no. (little number before name): \_ \_

Expiry Date: \_ \_ / 20 \_ \_ (A photocopy of your Medicare Card is required if this is your first order)

Pension/Healthcare/SN/CN number: \_\_\_\_\_

Expiry Date: \_ \_ / \_ \_ / 20 \_ \_ (A photocopy of your Concession Card is required for your first order)

Do you require a receipt for your private health fund? Yes / No \_\_\_\_\_

Would you like us to keep your repeat prescriptions? Yes / No \_\_\_\_\_

**\*\*\*PLEASE COMPLETE FORM & SEND WITH PRESCRIPTIONS TO:**

**Chemist Australia  
P.O. Box 1001  
Fortitude Valley  
Qld 4006**