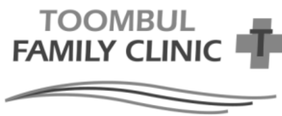

We request the following details for two purposes. Firstly, we are legally required to maintain certain minimum information about our patients in addition to the medical records kept by your doctor. Secondly and more importantly, this information assists in gaining the best health outcomes for you by facilitating communication with specialists and with relatives in cases of medical emergency.

Mr. Mrs. Miss Ms Master Dr Religious Title Other **PLEASE PRINT CLEARLY**

First Name: ______________________ **Middle Name:** ___________________ **Preferred Name:** __________________________

Surname: ______________________________________ **Date of Birth:** ___/___/____ **Sex:** Male / Female / Transgender

Do you self identify as being: **Aboriginal:** Yes/No - **Torres Strait Islander:** Yes/No **Ethnicity:** ____________________

Medicare Card Number: ______________________________ **Reference Number:** _______ **Expiry Date:** ____/____

HCC / DVA / Pension Number: ______________________________ **Type of Pension:** _________ **Expiry Date:** ____/____/____

These Cards MUST be Presented to Reception

Address: ____ Suburb: _______________________ Post Code: __________

PO Box: ____ Suburb: _______________________ Post Code: __________

Home Phone: _______________________ Work: ______________________ Mobile: ____________________________

Do you consent to receive text messages from the clinic for appointments; results and recalls: [ ] YES [ ] NO

Email: ____

Marital Status: Single / Married / Widowed / Divorced / De-Facto / Separated

Occupation: _______________________ **Country of Birth:** _______________________ **Year Arrived in Australia:** __________

Preferred Language Spoken: _____________________ **Health Insurance:** Extras / Hospital / Both **Fund:** ___________________

Next Of Kin Full Name: ________________________________ Ph: ________________________ Relation to you: _____________

Emergency Contact Name: ______________________________ Ph: ________________________ Relation to you: ____________

Patient Consent Form

From 21 December 2001 the Privacy Act requires private medical practices to obtain your consent to collect personal information about you. Please read this information carefully and sign where indicated below. The medical practice collection information from you for the primary purpose of providing necessary health care. We require you to provide us with your personal details and full medical details so that we may assess, diagnose, treat and be proactive in your health care needs properly and we will use the information you provide us in the following ways: Recall & reminder system, if you do not wish to be included please let the staff know.

Administrative purposes in running our medical practice; billing purposes, including compliance with Medicare & health Insurance Commission requirements; Disclosure to other doctors on the practice including locums for your ongoing care if your usual doctor is not available; Disclosure to others involved in your health care, including treating doctor and specialists outside this medical centre. This may occur through referral to other doctors or medical tests and in the response or results returned to us following referrals. **I assign my right to benefits to the practitioner who rendered this service.**

Disclosure for statistical research and quality assurance activities to improve individual and community health care and practice management. Please be advised that your personal details such as your name address and date of birth are withheld in these situations. Therefore your identity is protected. You may elect for your information to be excluded in such activities. Please place a line through this clause if you prefer your information to be excluded.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a private policy on handling patient's information. I understand that I am not obliged to provide any information requested of me but that failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might be withheld. I understand I will be given an explanation in these circumstances.

SIGNED: ____ **DATE:** _______________

PLEASE PRINT NAME: ____

FULL NAME: ____________________________ **Date of Birth:** / /

I consent to receive health reminder recalls (either via text, phone or email): [ ] YES [ ] NO

What is you preferred method of contact:

Home number / Work number / Mobile number / Email / Post

ALLERGIES: Do you have any allergies to medications, food, medical products [ ] YES [ ] NO

If **Yes**: :Allergic to: ____

Type of reaction: ___________________________ Severity (e.g. mild/severe): ____________________

MEDICAL HISTORY:

*****************<u>**Do you have any significant past medical history? □ YES / □ NO**</u>*****************

Have **you** or a **family member** ever suffered from any of the following health issues?

Please tick yourself or write relative's title (e.g. Mother/Father/Sibling/Grandparent)

Disease	You	Family Member	Disease	You	Family Member
Diabetes			Kidney Disease		
Chronic Lung Disease			Thyroid Disease		
Asthma			Liver Disease		
Heart Condition			Autoimmune Disease		
High Blood Pressure			Depression/Anxiety		
High Cholesterol			Other		
Stroke					

If you answered **YES** to any of the above for **yourself**, please give details and which year diagnosed:

____

____

____

____

OPERATIONS: Have you had any operations? Please name them and the year performed.

____

____

____

____

CURRENT MEDICATIONS: please list, including over the counter medications, vitamins etc

____

____

____

____

SOCIAL HISTORY:

Do you have children? [ ] Yes [ ] No How many? _______
Do you live alone? [ ] Yes [ ] No
When was the last time you travelled overseas and where to? ____________________________

 PLEASE TURN OVER

SMOKING HABIT status:

[ ] *Never smoked*
[ ] *Ex-Smoker* - What year did you quit? _______ What year did you commence? _______
[ ] *Smoker -* How often? [ ] Daily [ ] Weekly [ ] Less than Weekly
How many? _______ What year did you commence?
Are you planning to quit? [ ] Yes [ ] No

ALCOHOL HABIT status:

How often do you drink alcohol?
[ ] Never [ ] Monthly or less [ ] 2-4 times a month [ ] 2-3 times a week [ ] 4 or more times a week

On a typical day that you drink, how many standard drinks do you usually have?
[ ] 1 or 2 [ ] 3 or 4 [ ] 5 or 6 [ ] 7 to 9 [ ] 10 or more

How often would you have more than 6 standard drinks on 1 occasion?
[ ] Never [ ] Less than monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily

Are you concerned about your drinking? [ ] Yes [ ] No

MEASUREMENTS: ** Let Reception staff know if you would like these measured for you

Height : _______ cm **Weight** _______ Kg **Waist:** _______ cm

IMMUNISATION status:

If completing this form for a **CHILD,** are their immunisations **up to date?** [ ] Yes [ ] No

If completing this form for an **ADULT**, are your immunisations **up to date?** [ ] Yes [ ] No

Please list what immunisations you have had and when you had them:

Immunisation	Date	Immunisation	Date
Tetanus		Pertussis (Whooping Cough)	
Shingles		Pneumococcal (Pneumonia)	
Measles			

HEALTH PREVENTION FEMALE PATIENTS:

What month & year was your last Pap Smear? ________/__________ Was it Normal [ ] Yes [ ] No

Have you ever had a Mammogram or Breast Check? [ ] Yes [ ] No When ______/_______

HEALTH PREVENTION MALE PATIENTS:

Have you had a prostate check-up? [ ] Yes [ ] No When______/______

Name:____

Signed:____

Date: / /