Mt Ommaney FAMILY CLINIC

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Patient Information Form

We would like you to be aware before your consultation that we will not prescribe narcotic medications – these are drugs of addiction and subject to State prescribing laws.

PLEASE TICK THAT YOU HAVE READ THIS NOTE [ ]

Title	**□Mr □Mrs □Miss □Ms □Dr □Other.....**				
Name (as on Medicare)		**Preferred name**			
Surname					
Date of Birth		**Gender:**	**□Male □Female □Trans Gender**		
Medicare Number		**Ref:**		**Exp Date**	
DVA Number		Gold/White (Please circle)		**Exp Date**	
Pension Number				**Exp Date**	
Healthcare No.				**Exp Date**	
Private Health				**Exp Date**	
Residential Address					
				Postcode	
Mobile Phone		**Work Phone**			
Home Phone		**Email**			
Postal Address					
□ As Above					
□ Complete if different				**Postcode**	
Country of Birth		**Language spoken**			
Cultural Background	Ethnicity i.e. Chinese, Italian, Indian				
Are you?	□ Yes, of Aboriginal origin □ Yes, of Torres Strait Islander origin □ Yes, of both Aboriginal & Torres Strait Islander origin □ No, none of the above				
Occupation					
Marital Status	□ Single □ Married □Widowed □ Divorced □ De facto □ Separated				
Next of Kin	**Name:**			**D.O.B:**	
Address:			**Suburb:**		
Phone:		**Relationship:**			
Emergency	**Name:**				
□ Same as above	**Address:**		**Suburb:**		
□ Complete if different	**Phone:**	**Relationship:**			
If we needed to contact you What is your preferred method? □ Sms □ Phone □ Email Mail					
Do you wish to have any relevant health reminders sent to you? □ Yes □ No					
USUAL DOCTOR	If you usually attend another practice please complete the following:				
Practice Name					
Doctor's Name					
Address					
Phone					

How did you hear about our Clinic?

□ Referred by another doctor	□ Word of mouth i.e. another patient etc.
□ Local advertising	□ Yellow pages
□ Web/internet	□ Other

A Few Questions About You

Do you assign your right to a Medicare benefit if applicable?	**Yes/No**

HEIGHT: _____cm WEIGHT: _____kg

ALLERGIES: Do you have any allergies or are you sensitive to any drugs or dressings?

□ **Yes** □ **No** □ **Unsure**

If yes, details: _____ i.e. Reactions – Rashes, Swelling, Itchy

HEALTH HISTORY: Do you have or had a history of:

□ **No significant past health history**

□ Asthma	Year diagnosed:	□ Chronic Illness	Year diagnosed:
□ Diabetes	Year diagnosed:	□ Hypertension	Year diagnosed:
□ Operations Others	Year diagnosed:		Year diagnosed:
□ Others	Please indicate:		Year diagnosed:

Females Only: Have you had?		**Males Only: Have you had?**	
● Pap smear	□ Yes □ No -When?	● Prostate Check	□ Yes □ No -When?
● Breast check	□ Yes □ No -When?	● Overall check	□ Yes □ No -When?

CURRENT MEDICATIONS (Including over the counter medications, vitamins and minerals):

□ **No Current Medications**

*	*
*	*

FAMILY HISTORY: Has any member/s of your family had? (Please indicate and give details)

□ Diabetes		□ Melanoma		□ Other Cancer	
□ Asthma		□ Bowel Cancer		□ Other Illness	
□ Heart Disease		□ Breast Cancer		□ High Blood Pressure	
□ Mental Illness		□ Prostate Cancer		□ Thyroid	

CHILDREN IMMUNISATION: If completing this form for a child is their immunisation up to date? □ Yes □ No

SOCIAL HISTORY: Do you?

SMOKE	□ Ex Smoker				
	□ Yes	**Frequency:**	Day □	Week □	Month □
	□ Never	Number of cigarettes:			
Year commenced:		**Duration:**			
Stage of change assessment:	Not ready □	Unsure □	Ready □	Recent quitter □	

DRINKING:	□ No	□ Yes:		
1. How often do you have a drink containing alcohol?				
□ Never	□ Monthly or less	□ 2-4 times a month	□ 2-3 times a week	□ 4 or more times a week
2. How many standard drinks contacting alcohol do you have on a typical day?				
□ 1 or 2	□ 3 or 4	□ 5 or 6	□ 7 to 9	□ 10 or more
3. How often do you have six or more drink on one occasion?				
□ Never	□ Less than monthly	□ Monthly	□ Weekly	□ Daily or almost daily
Concerned about drinking?		□ Yes	□ No	□ Don't know

Do you have any health concerns you would like to mention?_____

My Health Record Online

1. Do you have a My Health Record? □ No □ Yes

Consent

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used of disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it is collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and Health insurance details, data collected from observations and conversations with you, photographs and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, third party providers (specialists) and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified person e.g. General Practice Managers.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

If you wish to opt out of any of any of the above, please speak with the Practice Manager.

Patient Name: (Please Print) _____

Signature: _____ **Date:** _____

If not patient signing – Your Name (Please Print) _____