|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. The purpose of this questionnaire is to help your doctor to assess your health needs. This information is treated confidentially.  **Doctor seen on initial consultation: Date:** | | | | | | | | | | |
| **Male /Female /Other (Circle one) Title** | | | | 🞏 Dr 🞏 Mr 🞏 Mrs 🞏 Ms 🞏 Miss | | | | | | |
| **Surname** | | | | **First Name** | | | | | | |
| **Occupation** | | | | **Date of Birth** | | | | | | |
| **Street Address** | | | | **Suburb and Post Code** | | | | | | |
| **Mobile Phone :** | | | | **Home Phone:** | | | | | **Work Phone:** | |
| **Medicare Number & Ref #:**  **Exp: /** | | | | **Next of Kin** Name:  Relationship: | | | | | NOK Contact no: | |
| **Pension Number** #: Exp: / | | | | 🞏 **DVA Gold** 🞏  **DVA White** (Please tick one) | | | | | #:  Exp: / | |
| **HCC Number** #: Exp: / | | | | **Private Health Cover:** | | | | | **#:** | |
| **Patient Background -** Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds. | | | | | | | | | |
| **Do you identify as someone from a culturally and/or linguistic diverse background?** | | | | | | | | | |
| 🞏 No 🞏 Yes. Please elaborate: | | | | | | | | | |
| **To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?** | | | | | | | | | |
| 🞏 No 🞏 Yes – Aboriginal 🞏 Yes – Torres Strait Islander 🞏 Yes - Aboriginal & Torres Strait Islander | | | | | | | | | |
| **Your Health History - Do you have or have you had a history of the following?** (please elaborate) | | | | | | | | | | |
| 🞏 Operations/procedures: | | | | | | | | | | |
| 🞏 Asthma 🞏 Diabetes 🞏 Hypertension 🞏 Heart disease 🞏 Breast Cancer 🞏 Bowel Cancer | | | | | | | | | | |
| 🞏 Chronic Illness:  🞏 Other:  🞏 Hospital admissions in last 12 months? 🞏 No 🞏 Yes:  **FAMILY HISTORY of any of the above? (Please list condition and relationship):** | | | | | | | | | | |
| **Do you have any ALLERGIES or are you sensitive to drugs or dressings?** | | | | | | | | | | |
| 🞏 No 🞏 Yes. Please elaborate: | | | | | | | | | | |
| **Current Medications** | | | | | | | | | | |
| **Please list all current medications including over the counter medications, vitamins and minerals:**  **When was the last time you were immunised?** | | | | | | | | | | |
| Tetanus Booster | | 🞏 Yes. Date: 🞏 No  🞏 Don’t Know | | | | Influenza | 🞏 Yes. Date: 🞏 No  🞏 Don’t Know | | | |
| Pneumococcal | | 🞏 Yes. Date: 🞏 No  🞏 Don’t Know | | | | FOBT (faecal occult blood tests) | 🞏 Yes Date:  🞏 No | | | |
| **Do you use any of the following:** (list amount where appropriate) | | | | | | | | | | |
| Do you smoke? | 🞏 No 🞏 Yes Number \_\_\_\_ per day / \_\_\_\_ per week  **Have you tried to stop smoking? Yes / No Longest time without smoking: \_\_\_\_\_\_\_\_\_\_** 🞏 Ceased smoking Date: No of years smoking: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Do you drink Alcohol? | 🞏 No 🞏 Yes Number \_\_\_\_ per day / \_\_\_\_ per week / \_\_\_\_ per month  **Are you concerned about your drinking? Yes / no** | | | | | | | | | |
| Drug Use? | 🞏 No 🞏 Yes. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Measurements** | | | | | | | | | | |
| Height | \_\_\_\_\_\_\_\_\_ cm BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P: \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Weight | \_\_\_\_\_\_\_\_\_ kg Last cholesterol check? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_years/months | | | | | | | | | |
| **Exercise**  **How many times per week do you usually do 20mins of VIGOROUS physical activity that makes you sweat (jogging, running, swimming, tennis, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **How many times per week do you do 30mins of MODERATE physical activity that makes you breath harder than normal (digging in garden, dancing, golf)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Women’s Health** | | | | | | | | | | |
| **When did you last have?** | | | | | | | | | | |
| Pap Smear  **Any previous abnormal results?** | | | Date:  **Yes / No** | | 🞏 Not sure  COMMENT: | | | 🞏 Never | | |
| Rubella (German Measles) vaccine? | | | Date: | | 🞏 Not sure | | | 🞏 Never | | |
| Over 40yrs – when was your last mammogram? | | | Date: | | 🞏 Not sure | | | 🞏 Never | | |

**Do you consent to uploading your MyHealth Record (PCEHR) Yes / No**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_**

**Welcome to Koobil Street Medical – Privacy and Consent**

Please read this **consent form** carefully prior to signing.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your 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 details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

* Administrative purposes in running our general practice.
* Billing purposes, including compliance with Medicare requirements.
* Follow-up reminder/recall notices for treatment and preventative healthcare. This may be via letters or SMS.
* Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
* Accreditation and quality assurance activities to improve individual and community health care and practice management.
* 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.
* To comply with any legislative or regulatory requirements e.g. notifiable diseases.
* 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.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission for my personal information to be collected, used and disclosed as described above (including contact via SMS to my mobile phone number). I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_

If signing on behalf of another person please state relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_