Chermside Family Medical Centre

New patient information

We request the following details for two purposes. Firstly, we are legally required to ascertain specific information about our patients in addition to their medical records which will be kept by your doctor. Secondly, and most importantly, this information assists in gaining the best health outcomes for you by facility communication with specialists and with relatives in cases of medical emergency.

TITLE: (please circle)	Mr.	Mrs.	Ms.	Miss.	Master.	Dr.	Other: _____
GENDER IDENTITY:					**PRONOUNS:**		

FIRST NAME:		**SURNAME:**			
PREFERRED NAME:		**DATE OF BIRTH:**		**SEX:**	F / M

MEDICARE NUMBER:		**REFERENCE NUMBER:**		**EXPIRY DATE:**	___/___/____
HCC / DVA / PENSION (please circle)	**CARD NUMBER:**			**EXPIRY DATE:**	___/___/____
OCCUPATION:				**CHILD / STUDENT** (please circle)	

DO YOU SELF IDENTIFY AS: (please circle)	Aboriginal	Torres Strait Islander	Other culture: _____
COUNTRY OF BIRTH:			

HOME ADDRESS:		**SUBURB:**		**POSTCODE:**	
POST ADDRESS:		**SUBURB:**		**POSTCODE:**	

HOME PHONE:		**MOBILE NUMBER:**	
WORK PHONE:		**EMAIL ADDRESS:**	

MATRITAL STATUS: (please circle)	Single	Married	Widowed	Divorced	De-facto	Separated

NEXT OF KIN:		**RELATIONSHIP:**		**CONTACT NUMBER:**	
EMERGENCY CONTACT:		**RELATIONSHIP:**		**CONTACT NUMBER:**	

Patient Consent form:

From 21st 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.
This medical practice collects 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. We will use the information you provide us in the following ways:

- Recall and reminder system: if you do not wish to be included, please notify staff or your Primary Care Physician
- Administrative purposes in running our medical practice; billing purposes, including compliance with Medicare and Health Insurance Commission requirements; disclosure to other doctors in 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 doctors and specialists outside this medical practice. This may occur through referral to other doctors or medical tests and in the response or results returned to use following referrals.
  I assign my right to benefits to the practitioner who rendered this service
- Disclosure for statistical research and quality assurance to improve individual and community health care and practice management. Please be advised that your personal details such as 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 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 failure to do so might compromise the quality of health care and treatment given to me.

NAME OF PATIENT / GUARDIAN NAME:			
SIGNATURE OF PATIENT / GUARDIAN:		**DATE SIGNED:**	

Chermside Family Medical Centre

Patient Medical Questionnaire

PATIENT NAME:		DATE OF BIRTH:	

PAST MEDICAL HISTORY: Have you ever suffered from?

CONDITION	YES / NO	DATE/S / COMMENTS	CONDITION	YES / NO	DATE/S / COMMENTS
Heart disease	YES / NO		Cancer	YES / NO	
Diabetes	YES / NO		Mental illness	YES / NO	
High cholesterol	YES / NO		Asthma	YES / NO	
High blood pressure	YES / NO		Lung disease	YES / NO	
Arthritis	YES / NO		Bowel problems	YES / NO	
Stroke	YES / NO		Eye problems	YES / NO	
Epilepsy	YES / NO		Thyroid disease	YES / NO	
Obesity	YES / NO		Joint pains	YES / NO	
Sleep apnoea	YES / NO		Rashes	YES / NO	
Kidney disease	YES / NO		Skin cancers	YES / NO	

DO YOU HAVE ANY KNOWN ALLERGIES?

KNOWN ALLERGY:	*KNOWN REACTION:*

CURRENT MEDICATIONS: Please list any current medications you are taking (prescription, herbal, vitamin supplements)

SIGNIFICANT FAMILY MEDICAL HISTORY: e.g. heart disease, cancer, mental illness or diabetes

FAMILY MEMBER:	*SIGNIFICANT MEDICAL CONDITION:*

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Patient Medical Questionnaire

PATIENT NAME:		DATE OF BIRTH:	

OTHER SIGNIFICANT MEDICAL HISTORY:		
CONDITION	*DATE/S*	*INFORMATION*

PAST SIGNIFICANT MEDICAL HISTORY: e.g. Past surgical procedures		
CONDITION	*DATE/S*	*INFORMATION*

LIFESTYLE HEALTH					
ARE YOU A SMOKER?	YES / NO	If yes: How many cigarettes per day? _____, How long have you been smoking for? _____			
	QUIT	When did you cease smoking? _____, How long did you smoke for? _____			
DO YOU DRINK ALCOHOL?	YES / NO	If yes, How often do you consume alcohol?	DAILY	WEEKLY	MONTHLY
	If yes,	How many standard drinks are consumed on these occasions?			

PREVENTATIVE HEALTH: have you had any of the following examinations and / or tests completed?

WOMEN			MEN		
EXAMINATION / TEST	**YES / NO**	**DATE/S:**	**EXAMINATION / TEST**	**YES / NO**	**DATE/S:**
Skin check	YES / NO		Skin check	YES / NO	
Bone density testing	YES / NO		Bone density testing	YES / NO	
Bowel cancer screening:			Bowel cancer screening:		
Faecal sample testing?	YES / NO		*Faecal sample testing?*	YES / NO	
Colonoscopy	YES / NO		*Colonoscopy*	YES / NO	
Pap smear	YES / NO		Prostate check	YES / NO	
Mammogram	YES / NO				