Central Clinic, Port Pirie

This complete medical history is important for you to obtain good health care. Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down. As you are providing us with health information please also read and sign a consent form to allow us to collect and use your health information.

Personal Details

Surname:_____ First Name:_____

Date of Birth:___/___/____

Marital Status (circle): Single, Married, Engaged, Divorced, de facto, have a partner, widowed, other

Address:_____ Suburb:_____

Phone Home:_____ Work:_____ Mobile:_____

Medicare number:_ _ _ _ _ _ _ _ _ _ Expiry _ _/_ _ PRN No. ___ Email:_____

Pension number:_ _ _ _ _ _ _ _ _ _ _Expiry:_ _/_ _ Aboriginal/Torres Strait Islander: Yes / No

Emergency contact: (name and phone number) _____

Any Religious Affiliation:_____ Current Occupation:_____

Nationality: _____

Previous Doctor:_____ Address:_____

Other family members attending this practice: _____

Preferred language:_____ Any special needs: _____

Any custody issues?_____

Medical History

Do you have any allergies to medicines or anything else? No □ Yes □

To what?_____ Reaction?_____

Current medications (including over the counter medication)

Name of medication	Strength	Times taken

Have you ever had any major operations or been admitted to hospital?

Year	Reason

Preventative Health

When was your last check for the following	Year		Year
Cholesterol		Bowel cancer	
Blood Pressure		HIV test	
Prostate check		Hepatitis test	
Pap smear			

Have You ever had:	*Year began*	*Active now✓*		*Year began*	*Active now✓*
Heart Problems			Serious infection		
Angina			Skin rashes, dermatitis, eczema, psoriasis		
High blood pressure			Epilepsy/fits/blackouts/strokes		
High cholesterol			Migraine		
Varicose veins, clots or blocked arteries			Asthma/emphysema		
Stomach ulcers			Hay fever/ sinus problems		
Gall stones			Eye/ ear problems		
Liver disease, Jaundice, Hepatitis			Back/neck problems		
Pancreatitis			Serious trauma		
Hernia/ bowel problems			Emotional disorder/ stress		
Rectal bleeding			Kidney / urine/ bladder problems		
Diabetes			Prostrate problems/ impotence		
Thyroid problem			Abnormal pap smear		
Gout			Sexually transmitted disease		
Arthritis/Joint problems			AIDS		
Cancer-where?			Intravenous drug use		

Immunisations:

	Year
Birth	
2 month	
4 month	
6 month	
12 month	
18 month	
4 year	
Year 7	
Year 10	

	Year		Year
Tetanus		Chicken Pox	
Rubella		Influenza	
Hepatitis A		Pneumonia	
Hepatitis B		Measles	
Meningococcal		Cholera	
Typhoid			

Family History:

Has anyone related to you ever had	**Relationship to you**	**Ever had ✓**	**Age of onset**	**Died from ✓**	**Age**
High blood pressure					
High cholesterol					
Heart attack/angina					
Stroke					
Anaemia					
Bleeding disorder					
Asthma /emphysema					
Tuberculosis					
Arthritis					
Diabetes					
Kidney disease					
Cancer or tumor					
Other					

Social	**Yes**	**No**	**Yes, now**	
• Cigarette	☐	☐	☐	_____ per day
• Alcohol	☐	☐	☐	_____ per week
• Intravenous drugs	☐	☐	☐	_____
• Other drugs (marijuana)	☐	☐	☐	_____
• Exercise	☐	☐	☐	_____

Health Information Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patients Name_____ Date_____/_____/_____
Patient's signature_____
Signed as Guardian for child_____ Name (printed) _____