**LOGAN HYPERDOME DOCTORS**

**CULTURAL BACKGROUND (please circle): ABORIGINAL or TORRES STRAIT ISLANDER**

**DO YOU IDENTIFY WITH ANY OTHER ETHNICITY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***MEDICARE NUMBER****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***NUMBER IN FRONT OF NAME****:\_\_\_\_\_*

***EXPIRY DATE****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Please circle: MR. MRS. MS. MISS. MAST.***

***SURNAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GIVEN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MOBILE PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\*CONTACT NUMBER YOU GIVE US PERMISSION TO CONTACT YOU ON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***PATIENT ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***SUBURB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POST CODE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***NEXT OF KIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NEXT OF KIN PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***RELATIONSHIP TO PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***EMERGENCY CONTACT (other than next of kin) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***EMPLOYMENT: FULL TIME CASUAL UNEMPLOYED RETIRED***

***OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***MARITAL STATUS: MARRIED DEFACTO DIVORCED WIDOWED SINGLE***

***CHILDREN: YES NO***

***HEALTH CARE OR PENSION CARD NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EXPIRY DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***DVA CARD NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EXPIRY DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***GOLD CARD: YES NO WHITE CARD: YES NO***

***DVA WHITE CARD CONDITIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_***

***GUARDIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**\*PLEASE INFORM THE DOCTOR IF YOU HAVE ANY ALLERGIES\***

***All information collected, forms part of your confidential medical records. This practice is committed to maintaining the confidentiality of your personal health information.***

**PRIVACY AND CONSENT FORM**

To enable on-going 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 or disclosed and record your consent or restrictions to this consent. **Please read this information carefully and sign where indicated below.**

This medical 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, treat and be proactive in your healthcare needs. This means we will use the information you provide in the following way:

* Administrative purposes in running our medical practice
* Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
* 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.
* Disclosure to other doctors in the practice and locums for the purpose of patient care. Please let us know if you do not want your records accessed for this purpose and will note your record accordingly.
* Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to “opt out” of any involvement.

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 privacy policy on handling patient information

and if I have not attended, my records may be destroyed by after 7 years.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access information collected about me, except in some circumstances

where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than set out above, my

further consent will be obtained. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH: \_\_\_\_/\_\_\_/\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DETAILS OF PERSON SIGNING IF **NOT** PATIENT:

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT: Mother/Father/Guardian/Sibling/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should you have any concerns regarding a breach of your privacy, please contact our Practice

Manager or your Doctor. If you wish to take the matter further and feel that you need to discuss

the matter outside the surgery, the Health Rights Commission may be contacted on 3234 0333.

**GENERAL HEALTH QUESTIONNAIRE**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_**

**ALLERGIES: Yes\_\_\_\_\_\_\_ IF YES PLEASE SPECIFY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_**

**CURRENT & PAST HEALTH PROBLEMS**

DIABETES \_\_\_\_\_\_\_\_\_\_\_\_\_Months/Years ASTHMA \_\_\_\_\_\_\_\_\_\_\_\_Months/Years

LIVER DISEASE \_\_\_\_\_\_\_\_\_Months/Years EPILEPSY\_\_\_\_\_\_\_\_\_\_\_\_\_Months/Years

DEPRESSION \_\_\_\_\_\_\_\_\_\_Months/Years LUNG DISEASE\_\_\_\_\_\_\_\_Months/Years

HEART CONDITION\_\_\_\_\_\_ Months/Years KIDNEY DISEASE\_\_\_\_\_\_\_Months/Years

HIGH CHOLESTEROL\_\_\_\_\_\_Months/Years OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Months/Years

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** **ALCOHOL**

Do you have a family history of the following? Do you drink daily? NO

 **Maternal/Paternal**

* Alcohol Problems **........ ..........** YES QUANTITY **...........**
* High Blood Pressure **........ ..........**
* Bowel Cancer **........ ..........** Do you drink monthly? NO
* Breast Cancer **........ ..........**
* Diabetes **........ ..........**  YES QUANTITY **...........**
* Heart Disease ....**.... ..........** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other **........ ..........**  **HOSPITAL ADMISSION**

What was the reason for your admission

**CURRENT MEDICATIONS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MEASUREMENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your height?\_\_\_\_\_\_\_\_\_cm

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your weight?\_\_\_\_\_\_\_\_kg

Do you use non-prescription drugs?

Yes (Please list below) No **IMMUNISATION**

 When was your last Tetanus?

Do you use recreational drugs? (Speed, Ectasy) Have you had 3 doses of Polio vaccine?

Yes (Please list below) No Have you had the Rubella vaccine?

 Yes No Unsure

**SMOKING**

Do you smoke? Yes No Have you had a pap smear in the last 2 Yrs

How many cigarettes do you smoke per day? YES NO UNSURE

5+ 10+ 15+ 20+

Are you an ex-smoker? Yes No

How many years ago did you quit?

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OFFICE USE ONLY: SCANNED\_\_\_\_\_\_\_\_ ENTERED BY NURSE\_\_\_\_\_\_\_**