Your Doctors®

Adult

Patient Details

Your NAME should be written as on your Medicare Card

TITLE	*FIRST NAME*	*PREFERRED NAME*	*SURNAME*	*DATE OF BIRTH*	*SEX*	
					M	F

ADDRESS

Street ______________________________ **Home** ______________________________

Suburb/Town ____________________**Postcode** __________ **Work** ______________________________

Email ______________________________ **Mobile** ______________________________
(PLEASE PRINT CLEARLY)

MEDICARE NUMBER LINE NUMBER ☐ MEDICARE NUMBER ☐☐☐☐☐☐☐☐☐☐ EXPIRY DATE ☐

We will send SMS reminders for some types of appointments: Are you happy for us to use your mobile number for this purpose? ☐ yes ☐ no

PENSION/CONCESSION HEALTH CARD No ______________________________ **Expiry Date**______________

VETERANS CARD No ______________________________ **Expiry Date** ______________ **RECORD No:**___________

PERSON TO CONTACT IN CASE OF EMERGENCY

1. Name ______________________________ **Relationship** __________________

Contact Phone No ______________________________ **Is this person an existing patient? YES / NO**

2. Name ______________________________ **Relationship** __________________

Contact Phone No ______________________________ **Is this person an existing patient? YES / NO**

ETHNIC / CULTURAL BACKGROUND

- ☐ ABORIGINAL
- ☐ TORRES STRAIT
- ☐ OTHER, please state ________________________

Where did you hear about Your Doctors?

- ☐ From a friend ☐ You live in the area
- ☐ From another medical professional ☐ Yellow Pages
- ☐Other:____

Your Doctors Patient Consent for use of Personal Health Information

a) Within the practice

I, (your name) ________________________ give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want any part of my medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor of this issue.

b) Outside the practice

Furthermore, I agree to allow my doctor to communicate relevant medical details to specialist doctors, hospital medical staff, pathology labs, and other health care providers e.g. physiotherapists, podiatrists, etc. involved in my medical care.

This practice from time to time participates in medical research projects with outside organisations. We stress that all information shared is **depersonalised** (i.e. names of patients are **NOT** given). If you expressly DO NOT want any of your clinical information used in this manner, please indicate with a cross in the following box ☐

The practice will from time to time send out reminders for various health checks. If you DO NOT wish to receive these reminders please tick the following box ☐

c) For Dependants

As guardian/parent of ______________________I authorise that their health information be also used in the above mentioned manner.

Your Signature – Patient/ Parent/ Guardian ➔ ____ Date _______________

Name of Witness ____ Signature of Witness ______________________________

Family Name ______________________ **First Name**______________ **D.O.B.** / /

Do you have any allergies or are you sensitive to anything (e.g. drugs, dressings, foods):

☐ No ☐ Yes *please list* ____

Please List Any Current Medications (including over-the-counter medications, vitamins and minerals)

____

____

Please list any specialist that you see regularly:_________________________________

YOUR HEALTH HISTORY:

Do you have, or have you a history of:

☐ Operations: *please list* ______________________________________

☐ Asthma

☐ Hypertension ☐ Diabetes

☐ Chronic Illness ☐ Mental health problems

☐ Any other medical conditions____

If you suffer from any chronic illness and need to see specialists or allied health providers, you may benefit from a GP management plan to help coordinate your care. PLEASE ASK ABOUT THIS.

Does anyone in your family have any chronic health problems?

☐ Cancer ☐ Asthma ☐ Diabetes

☐ Heart Disease ☐ Mental Illness ☐ Other______________

Females: When did you last have?

Pap smear Date_________ ☐ Not sure ☐ Never

Breast Check Date_________ ☐ Not sure ☐ Never

Males: When did you last have an overall check up? Date _________ ☐ Not sure ☐ Never

SOCIAL HISTORY:

What is your occupation? ____

To assist with appropriate health screening: Do you have sex with: ☐ Men ☐ Women

☐ Tobacco: ________ day / week or Ceased Smoking - date ___________

☐ Alcohol: ________ day / week / month (circle the one applicable)

☐ Drug use: ______________________________ (type and frequency)

☐ Exercise ______________________________ (type and frequency)

☐ Eating habits ____

MILITARY SERVICE:

Have you ever served in the defence force? (Australian/Other) ☐ Yes ☐ No

Have you ever deployed on military operations? ☐ Yes ☐ No

Some illnesses occur more frequently amongst certain ethnic groups, help us tailor your care by identifying your cultural background. Feel free to be as specific as you like.

☐ Aboriginal from ____________________

☐ Torres Strait Islander from ____________

☐ Pacific Islander from _______________

☐ European from ____________________

☐ Asian from______________________

☐ American from____________________

☐ African from_____________________

☐ Other, please state_________________

☐ Unknown

Immunisations: Please list the immunisations that you remember having.

____

____

____

____