Please consider the following information carefully and sign where indicated below. The 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 properly and we will use the information you provide us in the following ways: Recall & reminder system, if you do not wish to be included please let the staff know.

Consent to receive text messages from the clinic: [ ] YES [ ] NO

Administrative purposes in running our medical practice; billing purposes, including compliance with Medicare & 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 doctor and specialists outside this medical centre. This may occur through referral to other doctors or medical tests and in the response or results returned to us following referrals. I assign my right to benefits to the practitioner who rendered this service.

Disclosure for statistical research and quality assurance activities to improve individual and community health care and practice management. Please be advised that your personal details such as your 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 to 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 privacy policy on handling patient’s information. I understand that I am not obliged to provide any information requested of me but that failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might be withheld. I understand I will be given an explanation in these circumstances. I have been advised of the estimated costs in respect of the proposed medical services. I accept responsibility for payment of this account, including if any nominated insurer does not pay the anticipated costs or declines liability of any injury claims.

**Patient Consent Form**

From 21 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. The 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 properly and we will use the information you provide us in the following ways: Recall & reminder system, if you do not wish to be included please let the staff know.

**Consent to receive text messages from the clinic:** [ ] YES [ ] NO

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**Signed (patient, parent or guardian):** ___________________________ **Date:** ___________________________

**Please print name:** ___________________________ **Please present Medicare/Concession Card & ID with form**
MEDICAL HISTORY QUESTIONNAIRE

NAME: ________________________________ Date of Birth: / /

ALLERGIES:  Do you have any known allergies to medications, food or insect bites? □Yes / □No
If Yes - Allergic to:

__________________________________________________________________________________

MEDICAL HISTORY:
Have you or a family member ever suffered from any of the following – currently or in the past? Please tick or relative’s title eg Mother/Father/Sibling/Grandparent

<table>
<thead>
<tr>
<th>Disease</th>
<th>You</th>
<th>Family Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Fractures</td>
<td></td>
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<tr>
<td>Asthma</td>
<td>Bowel Cancer or Polyps</td>
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<tr>
<td>Diabetes</td>
<td>Breast Cancer</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Cancer of the Cervix</td>
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<tr>
<td>Thyroid Disease</td>
<td>Prostate Cancer</td>
<td></td>
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<tr>
<td>Osteoporosis</td>
<td>Any other Cancer</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Depression/Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered yes to any of the above please give details and which year diagnosed:

__________________________________________________________________________________

__________________________________________________________________________________

OPERATIONS: Have you had any operations? Please name the type and the year performed.

__________________________________________________________________________________

__________________________________________________________________________________

CURRENT MEDICATIONS: (please list, including over the counter medications, vitamins etc.)

__________________________________________________________________________________

__________________________________________________________________________________

SMOKING:
□ Have you ever Smoked? □Yes / □No
□ Ex-Smoker - What year did you quit? __________
□ Smoker - how many per day? ________________ What year did you commence? ________________
Are you planning to quit? □Yes / □No

ALCOHOL:
How often do you drink alcohol?
□Never, □Monthly or Less, □1-2 days per Month, □1-2 days per Week, □3-4 days per week, □Daily
  • On a day that you drink how many standard drinks do you have? ________________________
  • Would you ever have more than 6 standard drinks on 1 occasion? □Yes / □No
(IIf yes) How often? □Daily    □Weekly    □Monthly    □Less than Monthly
Cultural background:
______________________________

CHILDREN:
Do you have children? □ Yes/ □ No  How many? _______ How many still living at home?__________

IMMUNISATIONS:
(If completing this form for a child, are their immunisations up to date)
□ Yes / □ No

FEMALE PATIENTS:
What month & year was your last Pap Smear? ________/__________ Was it Normal □ Yes/ □ No
Have you ever had a Mammogram? □ Yes/ □ No  When ________/__________

MALE PATIENTS:
Have you had a prostate check-up? □ Yes / □ No  When__________/__________

If we are required to contact you, what is your preferred method of contact: □ Phone or □ Mail
You are automatically placed on our reminder system and receive notification when you are due for
immunisations, pap smears, health checks etc. Please advise if you prefer not to receive reminders.

Signed:___________________________________________

Date:    /    /

Thank you for taking the time to complete this questionnaire
This information will be recorded in your medical file as private and confidential