BALWYN CENTRAL MEDICAL

427 Whitehorse Road, Balwyn VIC 3103 | T: (03) 9830 2300 | F: (03) 9830 2355 | www.bcmedical.com.au

Once completed, please hand this registration form to reception

PATIENT INFORMATION

Title:	Name:	Surname:	D.O.B:

Phone: H: M: W:	Address: Postcode:	Occupation:
Are you Aboriginal or Torres strait islander? ◯ Yes ◯ No Are you of Aboriginal or Torres strait islander origin? ◯ Yes ◯ No		Ethnicity/Nationality:

Email:

If you have one of the cards below, please write the card numbers and expiry

◯ Centrelink health care card:
◯ Centrelink pension card: **Number:** **Expiry:**
◯ Centrelink Seniors health card:
◯ Dept. of Veteran Affairs (DVA) Gold Card:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ De facto

I give permission for **Balwyn Central Medical** to contact me via:

SMS	◯ YES	◯ NO
EMAIL	◯ YES	◯ NO

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Contact details:	Work phone no:

I understand that Balwyn Central Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Balwyn Central Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent Balwyn Central Medical to use and disclose my personal information (except when legal obligations must be met).

Patient / Guardian signature: Date:

Please tell us how you have heard about us: Friend / Family ◯ Flyer ◯ Newspaper ◯ Driving past ◯ Internet ◯ Catalogue flyer◯

CONFIDENTIAL MEDICAL HISTORY QUESTIONAIRE

Seen By **doctor**	___________
Scanned	□

Once completed please hand this to your doctor

Patient name: ____ Date of Birth: __________

What medical concerns do you wish to discuss with your doctor today?

Past Medical History Have you suffered from any of the following – currently or previously, **what year**?

□ Heart Problems	□ Stroke	□High blood pressure	□ Blood clots	□ Glaucoma
□ Epilepsy	□ Anxiety/Depression	□ Asthma	□ Bronchitis	□ Diabetes
□ Back Pain	□ Eye Problems	□ Thyroid Problems	□ Hep C	□ Hep B
□ Liver Disease	□ Kidney disease	□ Osteoporosis	□ Fractures	□High Cholesterol
□ HIV	□ Any other? ________________			

Preventative Health: Please tick the boxes where appropriate

ALL	**FEMALES**	**MALES**	**Any Illnesses, operations or hospital admission?**
Bowel Screening □ Date:	Pap smear □ Date:	Prostate check □ Date:	
Skin Check □ Date:	Mammogram □ Date:	Testis check □ Date:	
Unintended weight change □ _______ since____		Health check □ Date:	
	Immunisations:	Immunisations:	

Medications and Social History:

Please include ALL tablets, inhalers, patches, gels or injections – as well as any other ''natural'' remedies or supplements

MEDICATION	**DOSE**	**FREQUENCY**	
			SMOKER □ _________**per day** **STARTED**____________ **NON SMOKER** □ **EX-SMOKER** □ **QUIT IN** _______________
			ALCOHOL _________ **days per week** __________ **drinks per day**
			NON-DRINKER □
			RECREATIONAL DRUGS □ **Specify** ______________________________

FAMILY HISTORY	**MOTHER** Alive (Yes / No)	**FATHER** Alive (Yes / No)	**SIBLINGS**
Heart Attack	□	□	□
Bowel Cancer	□	□	□
Breast Cancer	□	□	□
High blood pressure	□	□	□
High Cholesterol	□	□	□
Stroke	□	□	□
Arthritis - Osteoarthritis/Rheumatoid?		□	□
Diabetes	□	□	□
Thyroid Disease	□	□	□
Haemochromatosis		□	□
Osteoporosis	□	□	□
Other:	□	□	□

ALLERGIES

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The Information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge.

Patient / Guardian Signature____

Name: ________________________________Surname:__________________________________Date________________