BALWYN CENTRAL MEDICAL

HEALTH GROUP

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 down the <u>card number and expiry</u>

◯ 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 to 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:

◯Family/Friend ◯Google ◯Health Engine ◯ HotDoc ◯ Facebook ◯ Instagram ◯ Catalogue/Flyer ◯ Driving past

Do you know about My Health Record? ◯ Yes ◯ No (If not, please ask our friendly reception staff)

Would you like our Clinical/Admin staff to register you for My Health Record ◯ Yes ◯ No

CONFIDENTIAL MEDICAL HISTORY QUESTIONAIRE

Once completed please hand this to your doctor

Seen By **Doctor** _____
Scanned ☐

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 admissions?**
Bowel Screening ☐ Date:	Pap smear ☐ Date:	Prostate check ☐ Date:	_____
Skin Check ☐ Date:	Mammogram ☐ Date:	Testis check ☐ Date:	_____
Unintended weight change ☐ _____ since _____	Health check ☐ Date:	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 _____** **EX-SMOKER ☐ QUIT IN _____ NON SMOKER ☐**
			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	☐	☐	☐
Hemochromatosis	☐	☐	☐
Osteoporosis	☐	☐	☐
Other:	☐	☐	☐

ALLERGIES

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 _____ Date _____