Patient Information Sheet – Adult

Title:_____ First Name:_____ Last Name:_____

Preferred name (if different from above):_____

Address:_____ State:_____ Postcode:_____

Home phone:_____ Mobile:_____ SMS Reminders Y □ N □

Email:_____ Date of Birth:_____

Emergency Contact Name:_____Relationship:_____Contact Number:_____

MEDICARE NUMBER:_____ Ref Number on Card:_____ Expiry____/____

DVA Card Number:_____ DVA Card Colour:_____
(Department of Veteran's Affairs)

Do you identify as: □ Aboriginal □ Torres Strait Islander □ Neither
If Aboriginal or Torres Strait Islander are you registered for CTG PBS Co-Payment Relief Y/N

Referring Doctor:_____

Usual GP (if different from above)**:_____ Usual GP Clinic:_____**

If there are any other interested parties you would like reports sent to please advise reception staff

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice
2. Billing purposes including compliance with Medicare and Health Insurance Commission requirements
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be collected
- I understand that I am not obliged to provide any information request 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 the information collected about me, except in some circumstances where as 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 the above, my consent will be sought.
- I consent to handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure of which I may notify this practice

CONSENT FOR TESTING

I consent to skin prick testing or skin patch testing to be performed if deemed necessary by my treating allergist

Patient Name: _____ Signature:_____ Date:_____

Do you have any <u>KNOWN</u> food, medication or skin allergies? (Please List) _____

_____

<u>IMMUNISATIONS</u>

Are you up to date? Yes □ No □

Check off any vaccination you have had (add year, if known):

□ Tetanus(TD)_____ □ Pertussis (TdAP)_____ □ Varicella (Chicken pox) shot/illness_____
□Pneumovax_____ □ Influenza (Flu Shot)_____□HepatitisA_____ □ HepatitisB_____
□MMR_____ □ Meningitis_____
□ Zostavax(Shingles)_____ □ HPV_____ □ Pneumococcal Vaccine_____

Tick the box if you have or have had:	✔	**Brief Description**
Asthma		
Shortness of Breath		
Bronchitis/Pneumonia		
Collapsed Lung		
Rhinitis/Blocked Nose		
Conjunctivitis		
Eczema		
Anemia		
Bleeding Tendency/Bruising		
Mouth Ulcers		
CVA/Stroke		
High Blood Pressure		
Diabetes		
Kidney/Bladder Problems		
Hepatitis		
Other Infections		
Epilepsy or Fits		
Heart Disease		
Palpitations/Angina/Chest Pain		
Bowel Issues (Bleeding/Constipation/Diarrhoea)		
Heartburn/Indigestion		
Arthritis (Type/Where)		
Morning Stiffness		
Dry Eyes/Mouth		
White/Blue Fingers (cold weather)		
Hair Loss		
Nerve problems		
Other Problems not listed above?		

SOCIAL HISTORY

Occupation:_____ Current ☐ Retired ☐

Do you smoke? Yes ☐ No ☐ Amount _____ **Have you every smoked?** Yes ☐ No ☐ Amount _____

Do you drink alcohol? Yes ☐ No ☐ Average amount _____ Daily ☐ Weekly ☐

Do you exercise? Yes ☐ No ☐ **How often?** _____

Do you have any special dietary requirements? (Explain) Yes ☐ No ☐ _____

PREVIOUS HOSPITALISATIONS

Name of Hospital	Year	Procedure

CURRENT MEDICATIONS

Please list all the medications/drugs you are currently taking, including contraception pill, vitamins, herbal remedies, inhalers and prescribed skin preparation etc.

Name	Dose	How Often

FAMILY HEALTH HISTORY

Do any of the following run in your family?

□ Thyroid problems □ Heart attack □ Diabetes □ Auto-immune Disease (such as Lupus) □ Kidney □ Disease Cancer Osteoporosis

Please tell us any relevant family health history (List diseases or condition that they have or had – or the cause of death)

Siblings: _____ Children:_____

_____ _____

Father: _____ Mother:_____

_____ _____

Paternal Grandfather: _____ Maternal Grandfather:_____

_____ _____

Paternal Grandmother: _____ Maternal Grandfather:_____

_____ _____