CRESTMEAD MEDICAL CENTRE **Unit 4 13-17 Julie St**
Phone 38035400 **Crestmead 4132**
Fax 38035511

PART A **Patient Information Details** **All patients are asked to complete this section**

Title : Mrs ☐ Mr ☐ Miss ☐ Ms ☐ Master ☐ Male ☐ Female ☐

Surname : _____ Given names : _____

Date of Birth : _____

Phone - Home : _____ Mobile : _____ Work : _____

Address : _____ Post code : _____

Postal Address (if different to Street) _____

Can we contact you via SMS for : appointment reminders , recalls and messages ? Yes ☐ No ☐

Emergency Contact Person _____ Phone - Home _____

Mobile : _____ Relationship : _____

Next of Kin if Different to Emergency : _____

Phone – Home : _____Mobile : _____ Relationship : _____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally diverse background ?

Are you of Aboriginal or Torres Strait Islander Origin ? ☐ No ☐ Yes , Aboriginal ☐ Yes , Torres Strait Islander

Please state other cultural background : _____

Privacy in Our Practice We value the doctor- patient relationship. Patient privacy is vital to such a relationship

To comply with the Australian Privacy Principles, we require your consent to collect personal information. Our doctors and staff collect information from patients primarily to provide proper care and treatment. Your information may also be used in the following ways :

- Administrative purposes in running the practice
- Billing and collection purposes
- Disclosure to other doctors , nurses , therapists and specialists outside this medical centre. This may occur through referral to other doctors, or for medical tests and in the reports of results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums and trainees attached to the practice, for the purpose patient care and teaching.
- Legal disclosure for any existing or future legal proceedings.
- You can assist in maintaining the accuracy of your information by advising the practice of changes to your personal contact details.

I consent to the handling of my information by this practice for the purpose set out above .

Signature : _____ Date : _____

How did you hear about the practice ? ☐Website ☐Internet☐Yellow pages ☐Friend/relative☐Other

Do you intend to have ongoing medical care provided by Crestmead Medical Centre ? ☐ yes ☐ no

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Part B Patients who will be continuing to use Crestmead Medical centre are asked to complete the following

Name _____ DOB _____

PART B Your health history - do you have or have you had a history of?

Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐
Any other Chronic Illness/ Disease _____

Past Surgical History
_____

Do you have any allergies or are you sensitive to drugs or dressings:
☐ Yes (If yes please list below) ☐No
_____

Immunisations - have you had the following immunisations?
Tetanus booster date_____ ☐ Don't Know ☐ Haven't had one

Children's immunisations - if completing this form for a child are their immunisations up to date?
☐ Yes ☐No

Current medications (including over the counter medications, vitamins and minerals):
_____
_____
_____
_____

Family history - have any members of your family had:

☐ Diabetes ☐ Asthma ☐ Heart Disease ☐ Mental illness ☐ Cancer

Social history : Occupation _____

☐ Tobacco: _____ day / week or Ceased Smoking - date _____
☐ Alcohol: _____ day / week / month (circle the one applicable)
☐ Drug use: _____ (type and frequency)

For those 65 years and older: when was the last time you were immunised?

Influenza	Date_____	☐ not sure	☐ never
Pneumococcal pneumonia	Date_____	☐ not sure	☐ never

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