Clifton Medical Practice

Thank you for choosing Clifton Medical Practice for your medical care.
We take this opportunity to welcome you to our clinic.
Please supply us with the following information.

Mr/Mrs/Ms/Miss/Master – (please circle)
Marital Status: (optional) ☐Married ☐Single ☐De Facto ☐ Divorced ☐Separated ☐Widowed
Sexuality: (optional) ☐Heterosexual ☐Homosexual ☐Bisexual ☐ Prefer not to specify

First name: _____ Surname: _____
Date of Birth: _____
Current Address: _____
_____

Mobile: _____ Home: _____
Email: _____
Occupation: _____

Do you consent to an SMS or email alert? ☐Yes ☐No

Next of kin/1st emergency contact name: _____ Relationship: _____
Next of kin address: _____

Next of kin phone number: _____

2nd emergency contact name: _____Relationship: _____

2nd emergency contact phone number: _____
Please supply us with NOK & 2nd emergency contact details – we are under a legal obligation to retain this information.

Medicare Number: _____ Ref. No. ____ Expiry Date: _____
Do you have a valid Concession Card? ☐ Yes ☐ No
☐ Pensioner ☐ Health Care Card ☐ Gold DVA
Concession number: _____ Expiry Date: _____

Private health insurer: _____ Member # _____

Do you have a current **work cover claim**? ☐ Yes ☐ No Claim # _____

Do you identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No
If yes, do you wish to register for Closing the Gap with Clifton Medical Practice? ☐ Yes ☐ No

If you are of another cultural background, do you give us permission to record this? ☐ Yes ☐ No

Nationality _____

Is an Interpreter required? ☐ Yes ☐ No

Confidential Medical History Questionnaire
Please take a moment to complete these details, so that your doctor can provide you with the best possible care.

Past Medical History:
Please tick box and circle problem if you have ever had any of the following:

☐ Anaemia/Bleeding Disorders ☐ Asthma/Emphysema/Lung Disease
☐ Seizures/Convulsions/Blackouts ☐ Hepatitis/Liver Disease ☐ kidney disease
☐ Diabetes ☐Cancer/Tumour/Leukaemia ☐ Deafness/Hearing Loss
☐ Vision Problems ☐ High Blood Pressure/Heart Disease
☐ Digestive Problems/Bowel Disease ☐ Mental Health/Psychology
☐ Arthritis ☐ Splenectomy ☐ Hysterectomy
☐ Other/past surgery:
_____
☐ Any other medical issues: _____

If there is a **family history** of any of the above illnesses, please provide details?
☐ Father: _____ ☐ Mother _____
☐ Sister: _____ ☐ Brother_____
Other: _____

Do you take any **prescribed medications**? ☐ Yes ☐ No
Please list: _____

Do you take any **herbal remedies**, vitamins or over the counter medications? ☐ Yes ☐ No
Please list _____

Do you use **recreational drugs**? ☐ Yes ☐ No
Please list: _____

Do you have any **allergies** to any medication/food/other? ☐ Yes ☐ No Known Allergies
Please list:
Allergy (eggs/nuts) _____ Type of reaction (ie: rash) _____
Severity of reaction: ☐ Mild ☐ Moderate ☐ Severe

Do you **smoke**? ☐ Yes - How many per day? _____ ☐ No ☐ Ceased

How often do you **drink alcohol**? ☐ Never ☐ daily ☐ weekly ☐ More than 3 times per week

How many drinks do you have on a typical day? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly
Are you concerned about drinking? ☐ Yes ☐ No

Immunisations
Your doctor or our nurse can access the Australian Immunisation Register online to review your immunisations.
Do you consent for us to access your immunisation history? ☐ Yes ☐ No

Females: When did you last have a:
Cervical screen (Pap smear) Date/Year _____ ☐ not sure ☐ never
Mammogram Date/Year _____ ☐ not sure ☐ never

Males: When did you last have:
Prostate screen Date/Year _____ ☐ not sure ☐ never

Have you had a Bowel cancer screening test (FOBT) ☐ yes ☐ no ☐ unsure
Have you had a skin cancer check? ☐ yes ☐ no ☐ unsure

An overall health check-up Date/Year _____ ☐ not sure ☐ never

How often to you **exercise**? ☐ daily ☐ weekly ☐ occasionally ☐ other

In your opinion do you eat a healthy **diet**? ☐ Yes ☐ No ☐ Unsure

Do you eat takeaway food each week? ☐ No ☐ 1 - 2 times ☐ 3 - 5 times

Do you know your approximate?
Height: _____ Weight: _____ Blood Pressure: _____

Other health comments: _____
_____
_____

Your Privacy and health information.
Clifton Medical Practice collects information from you for the primary purpose of providing optimum comprehensive quality health care. We require you to provide us with your personal details and a full medical history so that we may properly access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care.

Our practice provides our patients with preventive care and early case detection reminder letters such as immunisations, annual health checks, skin checks, cervical screening, and other recall & reminder letters.

Do you offer consent to participate? ☐ Yes ☐ No
Do you consent for us to access your My Health Record? ☐ Yes ☐ No

☐ I have read and understood the above information regarding my medical information.
☐ I confirm that there is no other information that I am aware of that would influence the medical treatment/advice to be provided.
☐ I am aware that I may be charged a fee for failure to attend my booked appointment.
Signature: _____ Date: _____

Thank you for your co-operation in taking the time to complete this important medical information. Clifton Medical Practice will endeavour to provide you with optimum care. If any time you are unhappy with your care or services provided, please do not hesitate to notify your doctor, our Practice nurse or our Practice Manager.

Your Privacy is important to us. It is the policy of this practice to maintain strict security of your personal health information. The information collected in this form will be always kept confidential. All staff at this practice are bound by a confidentiality agreement.