HARMONY HEALTH MEDICAL CENTRE

Patient Information Form

☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Master. ☐Dr. **First name**: **Surname**:

Preferred Name: *DOB:* *Male /Female /Other (please circle)*

Address:

Suburb: *State:* *Postcode:*

Telephone: (H) (W) (M)

Email:

Marital Status: *Country of Birth (if not Australia):* *Year of arrival in Australia:*
Occupation: *Language Spoken (if not English):*

Next of Kin: Relationship: Phone:

Emergency Contact: ☐ ***Same as Next of Kin OR***

Name: Relationship: Phone:

Do you identify with any ethnic or cultural group? Please tick one

☐ Non-Indigenous ☐ Aboriginal ☐ Aboriginal and Torres Strait Islander
☐ Torres Strait Islander ☐ Other (_____) ☐ I do not wish to disclose

Please complete billing information below and show your Medicare, Drivers Licence, Concession or Student card to the staff member at reception. ☐ Medicare Card Sighted ☐ ID Sighted

Medicare No:											Ref No:	Exp:

HCC/Pension: *Exp:*

Vet Affairs: *Exp:* Gold / White Card (please circle)

Uni Student ID: *Exp:* Full Time / Part Time (please circle)

CONSENT: Our practice meets legal obligations to comply with the Australian Privacy Principles and has an APP privacy policy available on request. Your medical record is a confidential document and it is our policy to maintain security of personal health information at all times, ensuring that this information is only available to authorised members of staff. It is important for us to collect patient information and maintain accurate patient records at all times in order for us to provide an optimal health care service. ***If you have any changes in your personal details, please advise reception as soon as possible. As a part of our care to you, our practice communicates in a few ways.***

We do not engage in direct marketing, but for the provision of best health care, we use the following:

- SMS appointment reminder. **Yes:** ☐ **No:** ☐ (please ✓)
- SMS contact for results recalls (1st line of contact). **Yes:** ☐ **No:** ☐ (please ✓)
- Reminder letters for health care specifically relevant to you. **Yes:** ☐ **No:** ☐ (please ✓)

For your health care, personal health information may need to be disclosed to others involved in your health care, and can be uploaded to your PCEHR if you wish. From time to time patient information may be de-identified and used for quality improvement activities and clinical audits. We may from time to time send out information in letters, SMS or email. Please advise us if you do not wish to receive this information from us.

I have read and understand the information above and have been provided with the APP Consent Information Sheet. I am aware of (please tick ✓):

- ☐ **The reasons why my information must be collected**
- ☐ **The practice's privacy policy on handling patient information**

PATIENT NAME: _____ SIGNED: _____ DATE: _____

HARMONY HEALTH MEDICAL CENTRE

Patient History Form

GUARDIAN OR CARER NAME & RELATIONSHIP (AS APPROPRIATE): _____

TODAY'S DATE: _____ FULL NAME: _____ SEX: _____

HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____ AGE: _____

Do you have any allergies or are you sensitive to any medications or dressings? No ☐ Yes ☐

If yes, please detail: _____

Please list any prescribed or over-the-counter medications, vitamins & herbals that you take:

_____

Do you have any medical conditions, past or present?

_____

FAMILY HISTORY

Have any members of your family had:		**DETAILS**
☐ Diabetes	Family Member:	
☐ Hypertension	Family Member:	
☐ Heart Disease	Family Member:	
☐ Stroke	Family Member:	
☐ Cancer	Family Member:	
☐ Mental Illness	Family Member:	
☐ Other	Family Member:	

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Living arrangements	☐ Alone	☐ Live with:
Do you have a carer?	☐ No	☐ Yes
Do you care for someone else?	☐ No	☐ Yes
Are you an elite athlete?	☐ No	☐ Yes
Obstetric History	Number of children	Ages
Are you pregnant?	☐ No	☐ Yes
Are you breastfeeding?	☐ No	☐ Yes
When was your last PAP smear?	Date:	

OCCUPATION:				Years:	
Are you retired?	☐ No	☐ Yes		Years:	
Previous Exposure to:	☐ Dust	☐ Asbestos	☐ Animals	☐ Radiation	☐ Other

Do you use any of the following substances?	
Alcohol	☐ No ☐ Yes Number ____ day / ____ week / ____ month
Drug Use	☐ No ☐ Yes Type _____ / Frequency _____
Tobacco	☐ No ☐ Yes Number ____ day / ____ week **or** ☐ Ceased smoking