AGHAPY MEDICAL CENTRE

PERSONAL MEDICAL HISTORY **PLEASE GIVE RECEPTION FIRST PAGE ONLY**

Title: (Please Circle) MR MRS MISS MAST MS

Gender (Please Circle) MALE FEMALE TRANSGENDER

First & Middle Name:

Surname:

Address:

Suburb & Postcode:

Date of Birth: Main language spoken:

Country of Birth: Ethnicity:

Home Phone: Mobile Phone:

Medicare No: Reference No: Expiry Date:

DVA Gold / White: Expiry Date:

Pension Number: / / / Expiry Date:

Health Care Card: / / / Expiry Date:

Private Health Cover:

Email Address:

Next Of Kin: Phone:

(Full Name & Telephone number)

PARTNER PARENT CHILD CARER OTHER **(Please Circle)**

Emergency Contact: Phone:

Are you of Aboriginal or Torres Strait Islander descent: YES / NO

If YES: **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait** ☐

Do you accept recall reminders via SMS? YES / NO

How did you hear about us? ______________________

Please Print Name: (Person filling out form) ______________________

Patients signature: (Or parent for a child) ______________________ Date:

THIS SECTION TO BE HANDED TO THE NURSE OR DOCTOR

Name: ______________________________

Date of Birth: ______________________________

Do you consent to a shared health summary being uploaded into MYHEALTH RECORD YES / NO

Do you have allergies or are you sensitive to drugs or dressings:

☐ YES (If yes, please list below) ☐ NO

____

Reaction: ______________________________

____

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

____

____

____

YOUR HEALTH HISTORY: **Do you have or have had a history of:**

ASTHMA: YES / NO ______________________________

DIABETES: YES / NO ______________________________

OPERATIONS: YES / NO ______________________________

CHRONIC ILLNESS: YES / NO ______________________________

HYPERTENSION: YES / NO ______________________________

CANCER: YES / NO ______________________________

OTHER: YES / NO ______________________________

YOUR FAMILY HISTORY: **Have any members of your family had:**

ASTHMA: YES / NO ______________________________

DIABETES: YES / NO ______________________________

HEART DISEASE: YES / NO ______________________________

CANCER: YES / NO ______________________________

MENTAL ILLNESS: YES / NO ______________________________

HEIGHT: ____________ CM'S WEIGHT: ____________ KG'S

SMOKING / ALCOHOL HISTORY:

Tobacco: YES / NO ________ Per Day / Week or Ceased Smoking - Date: ________

Alcohol: YES / NO ________ Per Day / Week / Month (Please circle one)

How many standard drinks do you have at a time? ____________

Drug Use: YES / NO (Type & frequency) ____________

SOCIAL HISTORY:

Do you live alone? YES / NO

Any further comments you feel your doctor needs to know about you to help with your care?

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PRIVACY AGREEMENT AND PATIENT CONSENT

I understand that Aghapy Medical Centre complies with the Privacy Act (1998) 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 Aghapy Medical Centre, 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 authorised representative and their insurer in the case of a work related consultation or service. I understand that I may withdraw my consent for Aghapy Medical Centre to use and disclose my personal information (except for when legal obligations must be met).

Signed: ____________________ Date: ____________