Your Doctors ™
Randwick

Adult

Patient Details

Your NAME should be written as on your Medicare Card

TITLE	*FIRST NAME*	*PREFERRED NAME* *(If different to First Name)*	*FAMILY NAME*	*DATE OF BIRTH*	*GENDER*

ADDRESS	*CONTACT DETAILS*
Home Address _____	**Home** _____
Suburb/Town _____ **Postcode** _____	**Work** _____
Postal Address _____	**Mobile** _____
Suburb/Town _____ **Postcode** _____	**Email** _____ **(PLEASE PRINT CLEARLY)**

We will use this email address to keep you updated about health happenings at the practice unless you tick this box. ☐
We will send SMS reminders for some types of appointments: Are you happy for us to use your mobile number for this purpose? ☐ **yes** ☐ **no**

MEDICARE NUMBER **LINE NUMBER** ☐ **MEDICARE NUMBER** ☐☐☐☐☐☐☐☐☐☐ **EXPIRY DATE** _____

PENSION/CONCESSION HEALTH CARD No _____ **Expiry Date**_____

VETERANS CARD No _____ **Card Colour** _____ **Expiry Date** _____

NEXT OF KIN	**PERSON TO CONTACT IN CASE OF EMERGENCY**
Name _____	**Name** _____
Contact Phone No _____	**Contact Phone No** _____
Relationship _____	**Relationship** _____
Is this person an existing patient? YES / NO	**Is this person an existing patient? YES / NO**

ETHNIC / CULTURAL BACKGROUND

- ☐ ABORIGINAL
- ☐ TORRES STRAIT
- ☐ OTHER, please state _____

Where did you hear about Your Doctors?

- ☐ From a friend
- ☐ You live in the area
- ☐ From another medical professional
- ☐ Yellow Pages
- ☐ Other:_____

Your Doctors Randwick Patient Consent for use of Personal Health Information

a) Within the practice

I give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want any part of my medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor of this issue.

b) Outside the practice

Furthermore, I agree to allow my doctor to communicate relevant medical details to specialist doctors, [such as hospitals, pathology labs, and other health care providers e.g. physiotherapists, podiatrists], etc. involved in my medical care.

c) For Dependants

As guardian/parent of _____I authorise that their health information be also used in the above mentioned manner.

This practice from time to time participates in medical research projects with outside organisations. We stress that all information shared is **depersonalised** (i.e. names of patients are **NOT** given). If you expressly DO NOT want any of your clinical information used in this manner, please indicate with a cross in the following box ☐

The practice will from time to time send out reminders for various health checks. If you DO NOT wish to receive these reminders please tick the following box ☐

Your Signature – Patient/ Parent/ Guardian ➔ _____ Date _____

Name of Witness _____ Signature of Witness _____

Family Name _____ **First Name** _____ **D.O.B.** / /

Do you have any allergies or are you sensitive to anything (e.g. drugs, dressings, foods):

☐ No ☐ Yes *please list* _____

Please List Any Current Medications (including over-the-counter medications, vitamins and minerals)

_____

_____

Please list any specialist that you see regularly:

_____

YOUR HEALTH HISTORY:

Do you have, or have you a history of:

☐ Operations: *please list* _____

☐ Asthma

☐ Hypertension ☐ Diabetes

☐ Chronic Illness ☐ Mental health problems

☐ Any other medical conditions_____

If you suffer from any chronic illness and need to see specialists or allied health providers, you may benefit from a GP management plan to help coordinate your care. PLEASE ASK ABOUT THIS.

Does anyone in your family have any chronic health problems?

☐ Cancer ☐ Asthma ☐ Diabetes

☐ Heart Disease ☐ Mental Illness ☐ Other_____

Females: When did you last have?

Cervical screening Date_____ ☐ Not sure ☐ Never

Breast Check Date_____ ☐ Not sure ☐ Never

Males: When did you last have an overall check up? Date _____ ☐ Not sure ☐ Never

SOCIAL HISTORY:

What is your occupation? _____

To assist with appropriate health screening: Do you have sex with: ☐ Men ☐ Women

☐ Tobacco: _____ day / week or Ceased Smoking - date _____

☐ Alcohol: _____ day / week / month (circle the one applicable)

☐ Drug use: _____ (type and frequency)

☐ Exercise _____ (type and frequency)

☐ Eating habits _____

MILITARY SERVICE:

Have you ever served in the defence force? (Australian/Other) ☐ Yes ☐ No

Have you ever deployed on military operations? ☐ Yes ☐ No

Some illnesses occur more frequently amongst certain ethnic groups, help us tailor your care by identifying your cultural background. Feel free to be as specific as you like.

☐ Aboriginal from _____

☐ Torres Strait Islander from _____

☐ Pacific Islander from _____

☐ European from _____

☐ Asian from_____

☐ American from_____

☐ African from_____

☐ Other, please state_____

☐ Unknown

Immunisations: Please list the immunisations that you remember having.

_____

_____