

DO YOU REQUIRE A TRANSLATOR? YES  NO

TITLE: \_\_\_\_\_ FAMILY NAME: \_\_\_\_\_ GIVEN NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ GENDER: \_\_\_\_\_

**STREET ADDRESS:** \_\_\_\_\_

SUBURB: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

**POSTAL ADDRESS**  SAME AS ABOVE

STREET ADDRESS: \_\_\_\_\_

SUBURB: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

MOBILE PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

DO YOU CONSIDER YOURSELF TO BE OF

- ABORIGINAL ORIGIN?  
 TORRES STRAIT ISLANDER ORIGIN?  
 ABORIGINAL AND TORRES STRAIT ISLANDER ORIGIN?

ETHNICITY: \_\_\_\_\_

MEDICARE NUMBER:

Reference  
Number

EXPIRY DATE: \_\_\_\_ / \_\_\_\_

DVA NUMBER: \_\_\_\_\_

EXPIRY DATE: \_\_\_\_ / \_\_\_\_

DO YOU HOLD ANY OF THE FOLLOWING CARDS?

- PENSIONER CONCESSION CARD  
 HEALTH CARE CARD  
 COMMONWEALTH SENIORS HEALTH CARD

CARD NUMBER: \_\_\_\_\_

EXPIRY DATE: \_\_\_\_ / \_\_\_\_

TYPE OF HCC? \_\_\_\_\_

EMERGENCY CONTACT: (used only in the event of an emergency)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

NEXT OF KIN:

SAME AS EMERGENCY CONTACT

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**Non-Attendance Fee.**

We understand that at times you may not be able to make your appointment.

We kindly ask that you notify the practice at least one hour before to cancel your appointment, if you fail to do so you may incur a non-attendance fee.

We appreciate and thank you for your understanding.

I have read and understood this policy.

Signature \_\_\_\_\_



Your private information is at all times treated confidentially with care and in accordance with the Australian Privacy Principles (APPs). A copy of our privacy policy is available on request.

I consent to receiving appointment reminders via SMS.

YES  NO

I consent to receiving Recall Reminders via SMS.

YES  NO

**I understand it is my responsibility to ensure all personal contact information is current and correct.**

**You can update your details at any time with our reception staff.**

## Personal & Health Information Consent

We respect your rights to privacy and take our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from:

- [www.merndamedical.com.au](http://www.merndamedical.com.au)
- Reception
- By calling (03) 9216 2600

We require your consent to collect personal information and health information about you. Please read this information carefully, and sign where indicated below.

Mernda Village Medical Centre collects information from you for the primary purpose of providing you healthcare services. We require you to provide us with your personal and health information such as your medical history so that we may provide our services to you. We will also use the information you provide in the following ways:

- Appropriately manage our practice, such as conducting audits and undertaking accreditation processes, manage billings and training staff;
- Effectively communicate with third parties, including Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare.

I have read the information above and understand why my information is collected and how it is used. I acknowledge that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of care provided to me.

Patient/Guardian Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Guardian Relationship: \_\_\_\_\_

**CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE**

(Once completed, please hand this section of the questionnaire directly to you Doctor)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Past Medical History** Have you suffered from any of the following – currently or previously?

- |   |   |  |                                      |                                    |
|---|---|--|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Heart problems   | <input type="checkbox"/> Stroke               | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Glaucoma  |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Anxiety / depression | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Back Pain        | <input type="checkbox"/> Eye problems         | <input type="checkbox"/> Thyroid problems    | <input type="checkbox"/> Hep C       | <input type="checkbox"/> Hep B     |
| <input type="checkbox"/> Liver disease    | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Fractures   | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hearing loss     | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Skin conditions     | <input type="checkbox"/> Cancer      | <input type="checkbox"/> HIV       |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Any other _____      |  |                                      |                                    |

**Preventative Health: Please tick the boxes where appropriate**

ALL	FEMALES	MALES	Any illnesses, operations or hospital admissions
Bowel screening <input type="checkbox"/> Date: _____	Pap smear <input type="checkbox"/> Date: _____	Prostate check <input type="checkbox"/> Date: _____	
Skin Check <input type="checkbox"/> Date: _____	Mammogram <input type="checkbox"/> Date: _____	Testes check <input type="checkbox"/> Date: _____	
Unintended weight change <input type="checkbox"/> _____ KG since (date) _____	Health check <input type="checkbox"/> Date: _____ Immunisations: _____	Health check <input type="checkbox"/> Date: _____ Immunisations: _____	

**ALLERGIES**

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SMOKING STATUS**

- 
- SMOKER
- 
- 
- NON SMOKER
- 
- 
- EX SMOKER
- 
- 
- QUIT DATE \_\_\_\_\_

**ALCOHOL AND SUBSTANCE STATUS**

- 
- NON DRINKER
- 
- STANDARD GLASSES PER WEEK \_\_\_\_\_
- 
- STANDARD GLASSES PER DAY \_\_\_\_\_
- 
- 
- RECREATIONAL DRUGS
- 
- SPECIFY \_\_\_\_\_

**FAMILY HISTORY**

	MOTHER	Alive <input type="checkbox"/>	FATHER	Alive <input type="checkbox"/>	SIBLINGS
Heart attack	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Bowel cancer	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Stroke	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Arthritis	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Blood clot/s	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Depression	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Haemachromatosis	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Other:					

**SOCIAL HISTORY**

- 
- MARRIED
- 
- SINGLE
- 
- 
- DIVORCED
- 
- DE-FACTO
- 
- OCCUPATION \_\_\_\_\_

**MEDICATIONS**

Please include ALL tablets, inhalers, patches, gels or injections – as well as any other “natural” remedies or supplements.

MEDICATION	DOSE	FREQUENCY

**OFFICE USE ONLY**

Data entered by (initials) \_\_\_\_\_