Wingham Family Health Clinic

We are required to hold accurate information about our patients so we can best meet your needs. Please complete this form and return to reception before seeing your Doctor.

Preferred title _____ **Surname**_____

Given Names _____**Preferred Name** _____

Date of Birth_____**M/F/Other**_____**Pronouns (if applicable circle)- He/She/They**

Address _____

_____

Phone: Home _____ **Work**_____ **Mobile** _____

Email _____ **Current marital status** _____

Medicare No ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref:** __ **Expiry** _____

Health Care Card/Pension No. _____ **Expiry** _____

Department of Veteran Affairs No: _____ **Expiry** _____

Private Health Fund Name _____ **Membership Number** _____ **Expiry** _____

If under 16 years of age, who is the legal guardian: _____

If under 16 years of age, who is responsible for your account: _____

Are you happy to receive appointment reminders and test results by SMS?: YES/NO

Do you identify as ☐ Aboriginal ☐ Aboriginal & Torres Strait Islander ☐ Torres Strait Islander or ☐ Non-Aboriginal or Torres Strait Islander

What is your **country** of birth? _____

What is your **cultural** background? _____

What is your main **language** spoken at home? _____

Next of kin _____

Relationship to Patient: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

Emergency Contact *(tick if same above*☐**):** _____

Relationship to Patient: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

Please tick if you have had problems relating to the following:

☐ **Heart** ☐ **Cancer** ☐ **Stroke** ☐ **Mental Health** ☐ **High Cholesterol**
☐ **High Blood Pressure** ☐ **Diabetes** ☐ **Kidney** ☐ **Lung/Asthma** ☐ **Thyroid**
☐ **Prostate** ☐ **Epilepsy** ☐ **Other:**

If yes for any, please give details including what year: ……

……

Operations: ……

……

Current medications and dosage: ……

……

……

Allergies or sensitivities: Yes: ☐ No: ☐ Details: ……

……

Family History: Do any of **your** relatives have (or have they had):

Condition		***Relationship to you***	***Aged Diagnosed***	***Description***
Heart Problems	Yes/No			
Cancer	Yes/No			
Diabetes	Yes/No			
Other: *eg. Mental health, blood pressure, stroke, inherited disorders etc.* ***(Please circle)***	Yes/No			

Do you have a Power of Attorney: Yes/No Details: ……

Do you have an Enduring Guardianship: Yes/No Details: ……

Smoking: Non-smoker: ☐ Ex-smoker: ☐ Year ceased: …… Smoker: ☐

Alcohol: How often do you drink alcohol: Never/Rarely: ☐ 2 – 4 days a month: ☐ 4+ days a week: ☐

How many drinks do you have on those days: ……

How often do you drink 6 or more drinks: ……

Social History:
Occupation(s) - if retired, previous occupation(s): ……

Living arrangements and who is in the home with you: ……

Are you a carer for someone: ……

Are your immunisations up to date: Yes: ☐ No: ☐ Details: ……

Last bowel test: …… Cervical test (Pap): …… Mammogram: ……

PRIVACY STATEMENT

To comply with the *Privacy Act 2001*, all patients need to provide consent for the following. Our full privacy policy is available on request.

- I understand and agree that my doctor will take a full medical history that relates to my medical condition and management, and that this information will be kept private and secure
- I understand and agree that relevant information may be obtained from and disclosed to other medical practitioners, such as GPs and Specialists, other health care providers, pathologists, hospital and day surgery units as necessary
- I understand and agree that all doctors within the practice may have access to my personal health information, and that all doctors and staff have signed a confidentiality agreement
- I understand that my doctor will not disclose my personal health information to a third party except as provided under the *Privacy Act 2001*
- I understand and agree that Wingham Family Health Clinic keeps a database and that this information may be used in an anonymous fashion for quality improvement and research purposes
- I understand that I may apply to access health records about me.

Signature of Patient _____Date_____

If not patient signing – your name: _____

Relationship to patient: _____

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