HealthSense MEDICAL CENTRE

☐Mr ☐Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Surname: Given Name:

Middle Name: Preferred Name:

Date of Birth: _____ Age: _____ Gender: ☐Male ☐Female ☐Transgender

Place of Birth: _____

Are you of or from Aboriginal or Torres Strait Islander Origin? ☐ Aboriginal ☐ Torres Strait Islander ☐ N/A

Street Address: _____

City/Suburb: _____ Postcode: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ E-mail: _____

How would you like your reminders sent: ☐ Phone / Mobile ☐ Post ☐ SMS

Medicare Number: _____ Ref No: (Next to Name)_____

Expiry Date: (Bottom Right Corner)_____

☐ Health Care Card ☐ Pension Card No: _____ Expiry Date: _____

☐ Department of Veteran Affairs Card Number: _____ Expiry Date: _____

Health Insurance Fund: _____ Membership No: _____ Expiry Date: _____

NEXT OF KIN: I authorise the following people to be contacted in the case of an emergency:

Name: _____ Relationship: _____ Contact No: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Contact No: _____

How did you get to know about us? ☐ Google ☐ Website ☐ Facebook ☐ Health Engine

☐ Community Newspaper ☐ Walk In ☐ Word of Mouth ☐ Chemist

Please see Reception if you are seeing the doctor regarding a Workers Compensation or Motor Vehicle Accident Claim for information regarding billing

Privacy Statement

Your Personal Health Information and your Medical Records may be collected, used and disclosed, including but not limited to the following reasons:

- **For Communicating relevant information with other treating doctors, specialists or allied health professionals**
- **For follow up reminders/recall notices**
- **For disease notification as required by law (e.g. infectious diseases)**
- **For use by all doctors in this practice, when consulting with you**
- **For research purposes (de-identified, meaning you are not able to be identified from the information given)**
- **For obtaining previous pathology and radiology results.**

If you have any concerns or wish to restrict access to your personal health information, please discuss these with your doctor.

Signature: _____ Date: _____

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Significant Family History:

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer

Other Significant Family History: _____

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression

Other Significant Family History: _____

Marital Status ☐ Single ☐ Married ☐ De Facto
Elite Athlete ☐ Yes ☐ No
Breast Feeding ☐ Yes ☐ No
☐ Heterosexual ☐ Homosexual ☐ Bisexual

Do you have any allergies: ☐ Yes (Please List) ☐ No

_____

_____

Do you use any of the following: Past Alcohol Intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol ☐ No. ☐ Yes Days per week _____ Standard drinks per day _____ Year Started: _____ Year Stopped: _____

Smoker ☐ No. ☐ Yes How many per day _____ Year Started _____ ☐ Ex-Smoker Ceased: _____

Accommodation: ☐ Own Home ☐ Relatives Home ☐ Private Lease ☐ Hostel ☐ Nursing Home
Lives With: ☐ Spouse ☐ Relative ☐ Friend ☐ Alone

Recreational Activities _____

Occupation: _____

Do you have any medical problems? Please list and provide details:

_____

_____

_____

Do you have a history of mental illness? Please List:

_____

_____

_____

Have you had any surgery? Please List and provide details:

_____

_____

_____

What medications do you currently take? Please list with doses:

_____

_____

_____

Females: When was your last pap smear and was it normal? _____

When was your last mammogram? _____

Males (>40 years): When was your last prostate check? _____

Do you regularly see other specialists? Please list:

_____

_____