KILCOY MEDICAL CENTRE

Welcome to our Practice

Our practice follows the Guidelines of Australian General Practice Accreditation Limited for the management of health information in private medical practices. This means that your personal health information is kept private and secure, as required by federal and state privacy laws.

Key Information

Title: Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Other: ☐ **(Please Tick One)**

Family Name: _____ **Given Names:** _____

Address: _____ **Town:** _____ **Postcode:** _____

Postal Address: _____ **Town:** _____ **Postcode:** _____

Date Of Birth: / /

Occupation: _____ **Country of Birth:** _____

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

Email: _____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ **Ref No.** ☐ **Expiry:** _____

Concession Card: ☐ Pensioner ☐ Health Care Card ☐ C'Wealth Seniors Card **(Please Tick One)**

Card Number: ☐☐☐ ☐☐☐ ☐☐☐ ☐ **Expiry:** _____

Dept. Veteran Affairs: ☐ Gold ☐ White ☐ Blue **(Please Tick One)**

File Number: ☐☐☐☐☐☐☐☐ **Expiry:** _____

Are you a member of a Private Health Fund? **Name of Fund:** _____

Level of Cover: ☐ Basic ☐ Intermediate ☐ Top **(Please Tick One)**

Gender: ☐ Male ☐ Female ☐ Other (Please specify) ☐ Prefer not to say

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Divorced ☐ Widowed **(Please Tick One)**

Are You Aboriginal or Torres Strait Islander:

☐ **No** ☐ **Yes** ☐ Aboriginal ☐ TSI ☐ AB/TSI **(Please Tick one)**

Notifiable Next of Kin

Family Name: _____ **Given Names:** _____

Next of Kin Relationship to you: _____

Address: _____ **Town:** _____ **Postcode:** _____

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

Family Name: _____ **Given Names:** _____

Next of Kin Relationship to you: _____

Address: _____ **Town:** _____ **Postcode:** _____

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

To provide the best medical care to you the Kilcoy Medical Centre asks for permission to put you on recall for any pathology results, health checks and regular other medical care that may come to our attention.

☐ **Agreed** **Signature:** _____

Height: _____ cm **Weight:** _____ Kg

Medical Information

Filling in the Medical Information section of this form is very helpful for your Doctor to have an understanding of your medical history.

Please list all current medications

Medication	Dose	Frequency

Please List any Allergies and Reactions

Allergy	Reaction	Any other information

Have you or a family member ever had any of the following conditions:

Type	Personal Diagnosis & Year	Diagnosed Relatives
Diabetes		
Asthma/other lung disease		
Heart Disease		
Kidney Disease		
High Blood Pressure		
Stroke/Epilepsy		
High cholesterol		
Bone Disease		
Ear, Nose and Throat		
Cancer		
Other		

Please list any operations

Type	Date (Year)	Other Information

Are you a: ☐ Non-Smoker ☐ Smoker Number of Cigarettes per day: _____

Year started smoking _____

Are you considering quitting Smoking? ☐ Yes ☐ No ☐ Undicided

☐ Ex-Smoker Qty Per Day _____ Quit Date _____(Year)

Do you consume Alcohol? ☐ Yes ☐ No

☐ less than Monthly ☐ 1-2 Days a week ☐ 3-4 Days a week
☐ 5-6 Days a week ☐ Daily

How often do you consume 6 or more standard drinks? _____

Please list any details of your social history (eg, Hobbies and Interests) _____

Previous health information is very important to our ability to provide you with the best medical care.

Would you like your previous medical records sent to Kilcoy Medical Centre

Yes ☐ No ☐ Undecided ☐

If yes, Please ask our staff for another form to complete requesting your previous health records to be sent by Kilcoy Medical Centre to your previous health professional.

Patient Privacy Information

To provide a high standard for medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other healthcare providers with patient consent. At times some of this information needs to be shared with other healthcare providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. The Practice is required to provide de-identified patient data to the federal Department of Health and Aged Care. The Practice undertakes research in collaboration with the Rural Clinical School of the University of Queensland which may include utilizing de-identified patient data.

Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor.

Signture of patient or guardian: _____

Date: _____