HEALTH SUMMARY
Please PRINT clearly

"At this practice we have a prescription policy on drugs of dependence. For further Information please check with our reception staff"

Mr. / Master / Mrs. / Ms. / Miss (please circle)

First Name : Preferred Name:	Surname:	Date of Birth:
Residential Address:		Suburb & Postcode:
Home Ph. (Including area code):	Work Ph.:	Mobile: Email:
Would you like to receive appointment reminders, Recalls/Results Via secure text message when due for your healthcare needs?	☐ YES	☐ NO
Medicare No:	Ref No:	Expiry Date:
Concession (please circle) Pension / Veterans Affairs / Health Care card Commonwealth Seniors Card	Number:	Expiry Date:
Occupation:	Country of Birth: Ethnicity:	
Emergency Contact or Next of kin - Full name:	Phone:	Relationship:

Cultural Background: Knowing your cultural background can help us provide healthcare that meets your individual needs: There may be a commonwealth programs that can assist us in your healthcare:

☐ ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ ABORIGINAL & TORRES STRAIT ISLANDER ☐ NO

Have you identified yourself as Aboriginal or Torres Strait Islander you may be eligible for free health assessment and Closing the Gap scheme. Would you like to discuss further with your GP or Nurse today? ☐ Yes ☐ No

Other Cultural Background (Mediterranean, Asian, African….**)** ____

Do you need interpreter ☐Yes ☐No?
If yes, please specify language spoken_______________________________

Allergies: Yes / No??

☐ **List Allergies here: 1.___________________ 2.__________________ 3.____________________ 4.____________________**

☐ **NON SMOKER** ☐ **SMOKER______/Day** ☐ **EX-SMOKER: Date ceased:________________**

☐ **NON DRINKER** ☐ **DRINKER______/ Day / week / Month (Circle the one applicable)**

PAST HISTORY: ☐ **ASTHMA** ☐ **DIABETES** ☐ **HYPERTENSION** ☐ **OPERATIONS** ☐ **OTHERS**

FAMILY HISTORY: ☐ **ASTHMA** ☐ **DIABETES** ☐ **HYPERTENSION** ☐ **HEART CONDITIONS** ☐ **CANCER** ☐ **MENTAL ILLNESS**

IMMUNISATION: ☐ **TETANUS** ☐ **HEPATITIS A** ☐ **HEPATITIS B** ☐ **INFLUENZA** ☐ **PNEUMOCOCCAL** ☐

COOLANGATTA MEDICAL CENTRE

PRESENT MEDICATIONS:

____

____

Herbal Medicine:

____

____

Vitamins/Minerals:

____

____

Would you like to tell us how you heard about us? (Please tick ☐ As applicable)

☐ Internet	☐ Flyers/Magnets	☐ Facebook	☐ Newspaper
☐ Yellow pages	☐ Family/Friends	☐ Walked past	☐ Health Engine
☐ Hotel	☐ Other (Please specify)		

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Would you like to transfer your care to this practice? Yes ☐ No ☐
If yes, please ask the reception staff for more information.

PATIENT CONSENT INFORMATION

The National Privacy Principles in the Privacy act give you a right to know that information we hold about you and a right to correct that information if it is wrong. To provide you with quality, ongoing health care, this practice needs to collect information about you. This will include your personal, medical and family health information. If you elect not to provide full information to your GP. You may compromise the quality of your ongoing medical care. Your attendance in this practice together with this information is taken as consent to the collection of this information. It will be used in the normal course of managing your healthcare and will include referrals to specialists, including radiology and pathology and allied health providers. In addition, access may be required as part of our ongoing professional, clinical and quality assurance programs. De- identified information may be used for research purposes. Patient should be aware that there are some instances where we are legally bound to disclose some of your personal information such as mandatory reporting of communicable diseases, Medico-legal and Work Cover issues. You have a right to see or obtain a copy of the information we hold about you, after an application you make in writing. If the doctor considers that releasing information to you may cause you physical or mental harm he /she may refuse your request, and will explain the reason to you. The fees associated with processing this request are not claimable from Medicare or your private health insurance.

I CONFIRM THAT I HAVE READ AND UNDERSTOOD THE PRIVACY INFORMATION.

SIGNATURE: (or Guardian)	
NAME:	**DATE:**