328 Glenelg Highway
WINTER VALLEY VIC 3358

Phone: 03 5332 1501
Fax: 03 5331 8860

NEW PATIENT INFORMATION FORM

Welcome to Carn-Brae Clinic. We require you to provide us with your personal details and a full medical history so that we may appropriately assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care.

PLEASE NOTE: We are unable to accept WorkCover or TAC patients, at this time.

FINANCIAL ARRANGEMENTS

Please be advised that we are a Private practice, bulk billing is only applicable to children aged under 16, DVA Card Holders and Pension Card holders aged 65 and over. Health Care Card holders will not be bulk billed.
Patients will be required to settle their account in full after the consultation. A list of standard fees is displayed at reception and in the waiting room.

RESULTS

It is the responsibility of the patient to contact the clinic to arrange follow up of test results.
Urgent matters and reminders will be dealt with in accordance with our recall and reminder policies.

PRIVACY POLICY

In accordance with the Privacy Act, all information collected in this practice is treated as confidential. To protect your privacy, this practice operates in accordance with this Act. A copy of our privacy policy is available at reception upon request.

MY HEALTH RECORD

You give permission for your Doctor to upload to your My Health Record.

If you do not consent to the participation in My Health Record please tick this box ☐

PATIENT CONSENT

I, _____ give permission for my personal information to be collected, used and disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Follow up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-indentified information is used.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

I have read and understood all the above information.

Patient/Guardian Signature:_____ Date:_____

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Patient Details

Family Name: Mr / Mrs / Miss / Ms _____

Given Names: _____

Date of Birth: ___ / ___ / _____ Age: _____ Gender: _____

Height: _____ Weight: _____

Cultural/Ethnic Background:
(eg. Aboriginal, Torres Strait Islander) _____

Address

Street: _____

Suburb: _____ Post Code: _____

Home: _____ Work: _____ Mobile: _____

Medicare and Concession Information

M/care #: __ __ __ __ - __ __ __ __ __ - __ Ref: __ Expiry: __ __ (m)/ __ __ (y)

Pension #: __ __ __ - __ __ __ - __ __ __ __ Expiry: __ __ (d)/ __ __ (m)/ __ __ (y)

DVA #: __ __ __ __ __ __ __ __ __ Gold ☐ White ☐ Orange ☐ Lilac ☐

Emergency Contact / Next of Kin

Name of Contact: _____

Relationship: _____ Phone: _____

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ALLERGIES / SENSITIVITIES	YES	NO	Specify…
Drugs	☐	☐	_____
Foods	☐	☐	_____
Other Allergies	☐	☐	_____

DIET / LIFESTYLE	YES	NO	Specify…
Drink Alcohol	☐	☐	_____
Other Drugs	☐	☐	_____

Usual Diet (circle) Normal Vegetarian Cardiac Diabetic Low Fat

PREVIOUS OPERATIONS / PROCEDURES:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

ONCOLOGY	YES	NO	Specify…	Family History ☐
Do you have Cancer?	☐	☐	_____	

TREATMENT	YES	NO	Specify…
Surgical Removal of Cancer	☐	☐	_____
Radiotherapy / Chemotherapy	☐	☐	Last Radiotherapy: ___ / ___ / _____ Last Chemotherapy: ___ / ___ / _____
Pharmacological Treatment	☐	☐	_____
Palliative	☐	☐	_____

PSYCHOLOGICAL	YES	NO	Specify…	Family History ☐
Anxiety / Depression	☐	☐	_____	
Psychological Disorder	☐	☐	_____	

NEUROLOGICAL	YES	NO	Specify…	Family History ☐
CVA / TIA	☐	☐	_____	
Parkinson's Disease	☐	☐	_____	
Epilepsy / Seizures	☐	☐	_____	
Migraines / Headaches	☐	☐	_____	
Sleeping Problems	☐	☐	_____	
Chronic Pain	☐	☐	_____	
Dementia / Memory Loss	☐	☐	_____	

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CARDIOVASCULAR	YES	NO	Specify…	Family History ☐
Angina / Chest Pain / AMI	☐	☐		
Hypertension / Hypotension	☐	☐		
High Cholesterol	☐	☐		
Thromboembolism	☐	☐		
Rheumatic Fever	☐	☐		
Cardiac Failure	☐	☐		
Arrhythmia	☐	☐		
Pacemaker / ACID Insitu / Stents	☐	☐		
Other Conditions	☐	☐		

RESPIRATORY	YES	NO	Specify…	Family History ☐
Tuberculosis	☐	☐		
Asthma	☐	☐		
Pneumonia / Bronchitis	☐	☐		
Emphysema	☐	☐		
Sleep Apnoea	☐	☐		
Cough / Sputum	☐	☐		
Smoker (Past or Current)	☐	☐		
Other Conditions	☐	☐		

METABOLIC / ENDOCRINE	YES	NO	Specify…	Family History ☐
Diabetes	☐	☐		
Thyroid Disorder	☐	☐		
Liver Disease	☐	☐		
Other Condition	☐	☐		

URINARY	YES	NO	Specify…	Family History ☐
Incontinency	☐	☐		
Difficulty Passing Urine	☐	☐		
Urgency / Frequency	☐	☐		
Frequent UTI's	☐	☐		

REPRODUCTIVE	YES	NO	Specify…	Family History ☐
Gynaecological Problems	☐	☐		
Other Problems	☐	☐		
If Female Currently Pregnant?	☐	☐		
Currently Breastfeeding?	☐	☐		

GASTROINTESTINAL	YES	NO	Specify…	Family History ☐
Incontinency (Faecal)	☐	☐		
Stoma-ileostomy / Colostomy	☐	☐		
Constipation	☐	☐		
Irritable Bowel Syndrome	☐	☐		
Diverticular Disease	☐	☐		
Ulcerative Colitis / Crohns	☐	☐		
Ulcers	☐	☐		
Hiatus Hernia / Reflux	☐	☐		
Other Conditions	☐	☐		

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BLOOD DISORDERS	**YES**	**NO**	**Specify…**	**Family History ☐**
Bleeding or Clotting Tendencies	☐	☐	_____	
Anaemia	☐	☐	_____	
Other Conditions	☐	☐	_____	

SKIN DISORDERS	**YES**	**NO**	**Specify…**	**Family History ☐**
Skin Disorder (Eczema / Psoriasis)	☐	☐	_____	

MUSCULOSKELETAL	**YES**	**NO**	**Specify…**	**Family History ☐**
Osteo / Rheumatoid Arthritis	☐	☐	_____	
Osteoporosis	☐	☐	_____	
Fractures	☐	☐	_____	
Soft Tissue Injuries	☐	☐	_____	
Gout	☐	☐	_____	
Bone Disease	☐	☐	_____	
Other Conditions	☐	☐	_____	

AUTOIMMUNE DISEASE	**YES**	**NO**	**Specify…**	**Family History ☐**
Speech / Swallowing Difficulties	☐	☐	_____	
Vision Impairment	☐	☐	Glasses ☐ Contacts ☐ Prosthesis ☐	
Hearing Impairment	☐	☐	Hearing Aid ☐ _____	
Language Spoken			_____	

IMMUNISATIONS	**YES**	**NO**	**Date Administered** (if known)
Childhood			
2 Months	☐	☐	___ / ___ / _____
4 Months	☐	☐	___ / ___ / _____
6 Months	☐	☐	___ / ___ / _____
12 Months	☐	☐	___ / ___ / _____
18 Months (born after 2012)	☐	☐	___ / ___ / _____
4 Years	☐	☐	___ / ___ / _____
Adult			
Tetanus	☐	☐	___ / ___ / _____
Flu Vax	☐	☐	___ / ___ / _____
Pneumonia	☐	☐	___ / ___ / _____
Cervical Vaccine	☐	☐	___ / ___ / _____

MEDICATIONS

Drug and Form	Strength	Dosage	Frequency