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.

FINANCIAL ARRANGEMENTS
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. A yearly membership fee of $44 is required

RESULTS
Patients are required to have an appointment with their Doctor to receive their results either via phone or in person

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 DETAILS:

Given Names: Mr/Mrs/Miss/Master/MX: _____

Family Name: _____

Date of Birth: ___ / ___ / _____ Sex at Birth: Male / Female Pronouns: _____

ATIS: Are you: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither Ethnicity: _____

Mobile Number: __ __ __ __ __ __ __ __ __ __ Do you consent to SMS? ☐ Yes ☐ No

Address: Street Number: _____ Street Name: _____

Suburb: _____ State: _____ Post Code: _____

MEDICARE AND CONCESSION INFORMATION ☐ Medicare Card sited by Reception

Medicare #: __ __ __ __ - __ __ __ __ __ - __ Ref: __ Expiry: __ __ (m)/ __ __ (y)

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

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

EMERGENCY CONTACT/NEXT OF KIN

Name of Contact: _____

Relationship to Patient: _____ Phone: _____

Do you have an Advanced Care Directive: ☐ YES - Please provide documents to Reception ☐ No

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MEDICAL DETAILS

Height: _____ Weight: _____ Waist: _____

Previous Operations / Procedures:

_____
_____
_____
_____
_____

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

Current Medications

Medication Name	Strength	Dosage	Frequency

Diet / Lifestyle

Alcohol: Yes No Specify: _____

Smoker: Yes No Specify: _____

Drugs: Yes No Specify: _____

IMMUNISATIONS

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

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MEDICAL HISTORY

ONOCOLOGY	Yes	No	Family History	Details
Do you have Cancer			Yes / No	
Surgical Removal of Cancer			Last Radiotherapy: ___ / ___ / _____	
Radiotherapy / Chemotherapy			Last Chemotherapy: ___ / ___ / _____	
PSYCHOLOGICAL				
Anxiety / Depression			Yes / No	
Psychological Disorder			Yes / No	
NEUROLOGICAL				
CVA / TIA			Yes / No	
Parkinson's Disease			Yes / No	
Epilepsy / Seizures			Yes / No	
Migraines / Headaches			Yes / No	
Sleeping Problems			Yes / No	
Chronic Pain			Yes / No	
Dementia / Memory Loss			Yes / No	
CARDIOVASCULAR				
Angina / Chest Pain / AMI			Yes / No	
Hypertension / Hypotension			Yes / No	
High Cholesterol			Yes / No	
Thromboembolism			Yes / No	
Rheumatic Fever			Yes / No	
Cardiac Failure			Yes / No	
Arrhythmia			Yes / No	
Pacemaker / ACID Insitu / Stents			Yes / No	
Other Conditions			Yes / No	
RESPIRATORY				
Tuberculosis			Yes / No	
Asthma			Yes / No	
Pneumonia / Bronchitis			Yes / No	
Emphysema			Yes / No	
Sleep Apnoea			Yes / No	
Cough / Sputum			Yes / No	
Smoker (Past or Current)			Yes / No	
Other Conditions			Yes / No	
METABOLIC / ENDOCRINE				
Diabetes			Yes / No	
Thyroid Disorder			Yes / No	
Liver Disease			Yes / No	
Other Condition			Yes / No	
URINARY			Yes / No	
Incontinency			Yes / No	
Difficulty Passing Urine			Yes / No	
Urgency / Frequency			Yes / No	
Frequent UTI's			Yes / No	
SKIN DISORDERS			Yes / No	
Skin Disorder (Eczema / Psoriasis)			Yes / No	

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REPRODUCTIVE	Yes	No	Family History	Details
Gynaecological Problems			Yes / No	
Other Problems			Yes / No	
If Female Currently Pregnant?			Yes / No	
Currently Breastfeeding?			Yes / No	
GASTROINTESTINAL				
Incontinency (Faecal)			Yes / No	
Stoma-ileostomy / Colostomy			Yes / No	
Constipation			Yes / No	
Irritable Bowel Syndrome			Yes / No	
Diverticular Disease			Yes / No	
Ulcerative Colitis / Crohns			Yes / No	
Ulcers			Yes / No	
Hiatus Hernia / Reflux			Yes / No	
Other Conditions			Yes / No	
BLOOD DISORDERS				
Bleeding or Clotting Tendencies			Yes / No	
Anaemia			Yes / No	
Other Conditions			Yes / No	
MUSCULOSKELETAL				
Osteo / Rheumatoid Arthritis			Yes / No	
Osteoporosis			Yes / No	
Fractures			Yes / No	
Soft Tissue Injuries			Yes / No	
Gout			Yes / No	
Bone Disease			Yes / No	
Other Conditions			Yes / No	
AUTOIMMUNE DISEASE				
Speech / Swallowing Difficulties			Yes / No	
Vision Impairment			Yes / No	
Hearing Impairment			Yes / No	
Language Spoken			Yes / No	

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-identified 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:_____