New Patient Questionnaire

Bray Park
FAMILY DOCTORS

We request the following details for two purposes. Firstly, we are legally required to maintain certain minimum information about our patients in addition to the medical records kept by your doctor. Secondly and more importantly, this information assists us in gaining the best health outcomes for you by facilitating communication with specialists and with relatives in case of medical emergency.

Title: __________ **First name:** _______________________________

Surname: _______________________________**Middle name:** ____________________

Date of Birth: ______/______/_________ **Sex (circle)** **Male** **Female** **Other:** ____________________________

Nationality (circle): Australian or/&Other (born in a country other than Australia): ____

Are you of Aboriginal/Torres Strait Islander descent (circle)? Yes No Both If yes are you:

- **Closing the Gap Registered? Yes/No- see reception to register**
- **NCACCH registered? No Yes, member number**________________

Do you have Private Health? No Yes, Which Fund: _____________________________________

Medicare No.: _______________________________________ **IRN:** ____ **Expiry Date:** _______________________

Pension/Health Care Card No.: ____ **Expiry Date:** ___________________

Patient Address: ____

Suburb: ________________________________**Postcode:**__________

Mobile: ____

Home Ph.: _______________________________ **Work:** _______________________________

Email: ____

(We use your email address for health reminders and practice information- not spam)

Next of Kin (Emergency Contact): Name: ____

Relationship to you: __________________________**Contact Ph. Numbers:** ____

Patient Consent

From December 2001, the Privacy Act requires private medical practices to obtain your consent to collect personal information about you. Please read this Information carefully and sign where indicated below.
The medical practice collects information from you for the primary purpose of providing necessary healthcare. We require you to provide us with all your personal details and full medical details so that we may assess, diagnose, treat and be proactive in your health care needs properly and we will use the information you provide in the following ways:
* Administrative purposes in running our medical practice
* Billing purposes, including compliance with Medicare and Health Insurance Commission Requirements
* Disclosure to others involved in your health care, including treating doctor and specialists outside this medical practice. This may occur through referral to other doctors or for medical tests and in response or results returned to us following referrals.
* Disclosure for statistical research and quality assurance activities to Improve Individual and Community Health Care and Practice Management. Please be advised that your personal details such as your name, address and date of birth are withheld in these situations. Therefore, your identity is protected. You may elect for your information to be excluded in such activities. Please place a line through this clause if you prefer your information to be excluded.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patients' information. I understand that I am not obliged to provide any information requested of me. But failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I consent to receive appointment & health reminders also health awareness via mobile number and/ or email.
I understand that failure to attendmultiple appointmentsor notify Bray Park Family Doctors of cancellation of an appointment may result in a fee being charged of between $65 - $110 with no Medicare rebate.
If not a +65 year old pension card holder or child under 16 I am aware there may be practice fees involved with my consultation.

Signature of Authorisation ____________________________________Date: _______/________/________

Information for Dr(Please complete this page first)

Current Medication: ____________________ ______________________ _______________________ __________________

_________________ _______________________ __________________ _____________________ _____________________

Allergies: □ Nil □ Yes (please list) ____

Personal Medical History (Past Illness/Operations) ____

____

Smoking:□ Never smoked □ Ex-SmokerYear Started:______ Stopped:________

□Current Smoker , Year Started________How many per day? __________ □ Vape

Alcohol: Non-drinker Y/N□ Consumes Alcohol Y/N How many a day? _______ How many days per week? ______

Elite Athlete? □Yes □No **Recreational Activities:** ____

Weight: ______________**Height:** ________________

Please give date of last check for:

Blood Glucosecheck_____/____/_____

Blood Pressure check____/____/____

Bowel Cancer Screening ___/____/____

Women - Please give date of last test for:

Mammogram 40-70yrs _____/____ /____

Cervical Screen/ PAP smear / /

FAMILY HISTORY

Mother alive? □Yes □No Age at death: _____ Cause of Death: ______________________

□Diabetes □High Blood Pressure □Heart disease □Stroke □Cancer

Father alive? □Yes □No Age at death: _____ Cause of Death: ______________________

□Diabetes □High Blood Pressure □Heart disease □Stroke □Cancer

Other Significant Family Medical History; (Please state relationship to you)

High Blood Pressure: Y/N _______________________ Diabetes: Y/N ______________________

Heart Disease: Y/N _________________ Cancer: Y/N Type: ____________

Other ____

Please turn over to complete details section.