

PATIENT INFORMATION FORM

Welcome to The Gympie Clinic. We are committed to providing our patients with the best care. To do this, it is essential that your health record and contact details are complete, accurate and up to date.

PERSONAL CONTACT INFORMATION

Surname: _____ Given Names: _____ Preferred Name: _____

Date of Birth: ____ / ____ / _____ Sex: Male Female Occupation: _____

Street Address: _____

Postal Address (if different to above): _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Preferred method of contact: Home Work Mobile – including SMS

Have you opted out of the eHealth Record? YES NO UNSURE

NEXT OF KIN

Name: _____ Relationship to you: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

EMERGENCY CONTACT (if different from next of kin)

Name: _____ Relationship to you: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

HEALTHCARE IDENTIFIERS

Medicare Number _____ Reference _____ Expiry ____/____

Health Care Card Number _____ Expiry ____/____

Commonwealth Senior Card _____ Expiry ____/____

Pension Card Number _____ Expiry ____/____

Department of Veterans Affairs (if applicable) Client Number _____ Expiry ____/____

Gold White DVA White Card Entitlements _____

CULTURAL IDENTITY

To assist with health initiatives – do you identify as Aboriginal and/or Torres Strait Islander?

Aboriginal Both NCACCH Number: _____
 Torres Strait Islander Neither (if applicable)

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures – do you identify as someone from a culturally and/or linguistically diverse background?

Yes Country of Birth: _____ Do you require an interpreter service? Yes - Language: _____
 No

YOUR HEALTH INFORMATION

MEDICAL HISTORY – Do you have a history of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Illness |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Mental Health Illness | <input type="checkbox"/> Other – details: _____ | |

SURGICAL HISTORY – Please list any surgeries you have had (and date if known):

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines, vitamins, fish oil etc):

ALLERGIES – Do you have any allergies or adverse drug reactions you are aware of? YES NO

Please state product/s and reaction/s: _____

IMMUNISATIONS – As far as you are aware, are all immunisations up to date? YES NO

FOR FEMALES – When was your last Pap Smear/Cervical Screening Test? _____ Breast Screen? _____

LIFESTYLE / SOCIAL INFORMATION

- | | | |
|---------|--------------------------------------|--|
| Smoking | <input type="checkbox"/> Smoker | Number of years of smoking: _____ |
| | <input type="checkbox"/> Ex-Smoker | Average Cigarettes per day: _____ |
| | <input type="checkbox"/> Non-Smoker | |
| Alcohol | <input type="checkbox"/> Yes | No of standard drinks _____ per day / week / month |
| | <input type="checkbox"/> Non-drinker | |

FAMILY HISTORY – Do any immediate family members have or had any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Illness |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Mental Health Illness | <input type="checkbox"/> Other – details: _____ | |

By signing below you are consenting to the collection of your personal information, and that it may be used or disclosed by the practice as per The Gympie Clinic privacy policy. You also consent to receive SMS correspondence from the Clinic unless you have opted out as indicated below.

This clinic uses SMS to improve communication between doctors and patients. SMS is used for:

- Appointment Confirmation and Reminders
- Result recalls (including informing you of negative results)
- Clinical Reminders (e.g. for regular injections, diabetes review or planned blood tests)
- Health promotion (e.g. influenza, meningococcal or shingles public health vaccination)

Please tick if you want to OPT OUT of receiving SMS

Patient or Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (printed): _____