# New Patient Information Form

PIVOTAL health

Welcome to our practice! We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and is accurate. Could you please assist us by completing the following information?

| Demographics | |
|---|---|
| Title | ☐ Dr ☐ Mr ☐ Mrs ☐ Ms<br>☐ Miss ☐ Other ____________ |
| Surname | |
| Given Name/s | |
| Gender | ☐ Male ☐ Female ☐ Intersex<br>☐ Prefer not to disclose |
| Date of Birth | |
| Country of Birth | |
| Marital Status<br>(please circle) | Single Defacto Married Widowed<br>Divorced Separated |
| Street Address | |
| Postal Address (if different than above) | |
| Home Phone Number | |
| Work Phone Number | |
| Mobile Phone Number | |
| Do you consent to receiving text messages? | ☐ Yes ☐ No |
| Email Address | |
| Do you consent to receiving emails? | ☐ Yes ☐ No |
| Do you have an electronic My Health Record? | ☐ Yes ☐ No |
| If no, are you interested in finding out about one? | ☐ Yes ☐ No |
| Medicare Number and<br>Reference Number (the number beside your name) | Card No. __ __ __ __ __ __ __ __ __ __/ __<br>Expiry Date: |
| ☐ DVA Gold ☐ DVA White<br>(Please tick which)<br>Condition for white (if applicable)<br>_______________ | Card Number:<br>Expiry Date: |
| Pension Number | Card Number:<br>Expiry Date: |
| Private Health Cover | ☐ Yes ☐ No |
| | ☐ Hospital ☐ Extras |
| | Name of Fund: |
| Next of Kin<br>(Name, Relationship and Telephone Number) | |

| | |
|---|---|
| Emergency Contact<br>(Name, Relationship and Telephone Number other than next of kin that can be contacted in emergencies) | |
| Occupation | |
| How did you find out about our practice? | |

**Reminder System**

Our practice provides our patients with preventative care and early case detection reminders such as immunisation, annual health checks, skin checks and pap smears.

| Do you wish to have any relevant health reminders sent to you? | |
|---|---|
| ☐ Yes | ☐ No |
| **If we need to contact you, what is you preferred method of contact?** | |
| ☐ Home Phone | ☐ Mail |
| ☐ Mobile Phone | ☐ Email |
| **To assist with health initiatives – Are you Aboriginal or Torres Strait Islander:** | |
| ☐ No | ☐ Yes, Torres Strait Islander |
| ☐ Yes, Aboriginal | ☐ Yes, Aboriginal and Torres Strait Islander |
| **What are the health related goals do you wish to achieve at your first appointment?** | |
| | |

*Please note that not all goals may be achieved at your first appointment, the GP will prioritise this list with you and cover what they can in the first appointment,

## Your Health History

To assist us in ensuring your Medical Record is accurate please complete the following Medical Questionnaire

| Have you suffered from any of the following – Currently or in the past? | | | |
|---|---|---|---|
| Condition | Year | Condition | Year |
| ☐ Heart Attack | | ☐ Asthma | |
| ☐ High Blood Pressure | | ☐ Diabetes | |
| ☐ Stroke | | ☐ Epilepsy | |
| ☐ Blood Clot(s)/DVT | | ☐ Liver Disease | |
| ☐ High Cholesterol | | ☐ Kidney Disease | |
| ☐ Anxiety or Depression | | ☐ Osteoporosis | |
| ☐ Glandular Fever | | ☐ Fracture(s) | |
| ☐ Cancer | | ☐ | |

| Please list current or past operations, hospital admissions, (if none write NIL) | |
|---|---|
| Year | Details |
| | |
| | |
| | |
| | |

| Past Screening Tests | |
|---|---|
| When was your last skin check? | |
| Ladies, when was your last Pap Smear? | |
| Ladies, when was your last breast check? | |
| Gentlemen over 50, when was your last prostate exam? | |
| Over 50's, when was your last bowel screen? | |

| Are you currently under the care of a specialist? | |
|---|---|
| ☐ Yes, please specify who | ☐ No |
| **Do you regularly see an Allied Health Professional e.g. physiotherapist, dietitian, podiatrist)** | |
| ☐ Yes, please specify who | ☐ No |

## Allergies

| Do you have any allergies or sensitivities to any drugs or dressings? | | |
|---|---|---|
| ☐ Yes, please specify | | ☐ No, Nil Known |
| Allergy | Type of Reaction | |
| | | |
| | | |
| | | |

## Current Medication

| Please list **ALL** tablets, inhalers, patches, gels, creams, or injections you currently take or use. Please include any 'natural' remedies such as herbal, homeopathic and vitamin supplements. | |
|---|---|
| **Name of medication** | **Dosage** |
| | |
| | |
| | |
| | |

## Immunisations

| Are you up to date with the following immunisations? | | | |
|---|---|---|---|
| Tetanus | ☐ Yes | ☐ No | ☐ Don't Know |
| Whooping Cough | ☐ Yes | ☐ No | ☐ Don't Know |
| Influenza | ☐ Yes | ☐ No | ☐ Don't Know |
| Pneumococcal | ☐ Yes | ☐ No | ☐ Don't Know |
| Polio | ☐ Yes | ☐ No | ☐ Don't Know |
| Hepatitis B | ☐ Yes | ☐ No | ☐ Don't Know |

## Family History

Has anyone in your close family suffered from the following?
(Please state the relative affected e.g. mother, father, sister, brother, maternal grandmother, paternal grandfather)

| Have you suffered from any of the following – Currently or in the past? | | | |
|---|---|---|---|
| Disease | Relative | Disease | Relative |
| ☐ Heart Attack | | ☐ Bowel Cancer | |
| ☐ High Blood Pressure | | ☐ Ovarian Cancer | |
| ☐ Stroke | | ☐ Cervical Cancer | |
| ☐ Blood Clot(s)/DVT | | ☐ Uterine Cancer | |
| ☐ High Cholesterol | | ☐ Prostate Cancer | |
| ☐ Diabetes | | ☐ Skin Cancer | |
| ☐ Thyroid Disease | | ☐ Any other cancer | |
| ☐ Breast Cancer | | ☐ Depression | |
| ☐ Schizophrenia | | ☐ Arthritis | |
| Other, please list | | | |

## Lifestyle History

| Smoking History | | | |
|---|---|---|---|
| ☐ Smoker | Number per day | | |
| ☐ Never Smoked | | | |
| ☐ Ex-Smoker | Quit Date | | |
| **Alcohol** | | | |
| ☐ Drinker | Days per week: | Drinks per session | |
| | Do you consider yourself to be an | | ☐ Occasional Drinker<br>☐ Moderate Drinker<br>☐ Heavy Drinker |
| ☐ Non-Drinker | | | |
| ☐ Previous Drinker | When you were drinking did you consider yourself to be an | | ☐ Occasional Drinker<br>☐ Moderate Drinker<br>☐ Heavy Drinker |

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# Health Information Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.
Administrative purposes in running our medical practice.

- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare 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 referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

*Please sign consent below

| | |
|---|---|
| I have read the information above and understand the reasons why my information must be collected. | ☐ |
| I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. | ☐ |
| I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. | ☐ |
| I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. | ☐ |
| I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice. | ☐ |
| **OR** | |
| I am unsure and would like to discuss this further with someone from the medical practice before I sign. | ☐ |

I, ____________________________ (printed name) confirm that the above information is true and correct to my knowledge.

**Patient’s name:**___________________________________ **Date:** ______________

**Patient’s signature:** _______________________________

*Thank you again for your time and we look forward to providing you with a professional and personalised health care service.*