Patient Information Sheet

Mr / Mrs / Miss / Ms / Dr / Other ________

Surname: ______________________________ Given Names: ______________________________

Address: ______________________________ Suburb: ______________________________

Postcode: ____________ DOB: ________________ Occupation: ______________________________

Phone H: ____________________ W: ____________________ Mobile: ____________________

E-mail: (PLEASE PRINT) ____

Do you consent to receiving emails, which will include clinical information, to the above email? YES / NO

Emergency Contact: ______________________________ Relationship: ____________________

Phone H: ____________________ W: ____________________ Mobile: ____________________

Medicare No: __________________________ Expires: ______________ Number Before Name: ________

Private Health Insurance: YES / NO Fund Name: ______________________ Member No: ______________

HCC/Pension No: ______________________ Expires: ______________ Type: ______________

Department of Veterans' Affairs No: ______________________________ Gold or White

Referring Doctor: ____

If this is not your regular GP please give details:

GP: ______________________________ Address: ______________________________

Physio: ______________________________ Address: ______________________________

Worker's Compensation/Third Party? YES/NO, If yes please fill in Worker's Compensation/CTP Form.

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. 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 doctors and specialists outside this medical practice as advised by you.

If you would like to see the detailed consent, please advise one of the administrative staff.

Signed: ______________________________ Date: ____________________

PATIENT HEALTH QUESTIONNAIRE

NAME: .... **DATE:** ....

The following is a list of common health problems. Please indicate 'Yes' or 'No' in the first column and list any medications or details beside.

	Do you have the problem?		Medications/Details (Please list)
	Yes	No	
Heart disease	❑	❑	
High blood pressure	❑	❑	
Asthma or pulmonary disease	❑	❑	
Diabetes	❑	❑	
Ulcer or stomach disease	❑	❑	
Bowel disease	❑	❑	
Kidney disease	❑	❑	
Liver disease	❑	❑	
Anaemia or other blood disease	❑	❑	
Overweight	❑	❑	
Cancer	❑	❑	
Depression	❑	❑	
Osteoarthritis, degenerative Arthritis	❑	❑	
Rheumatoid arthritis	❑	❑	
Back pain	❑	❑	
Other medical problems	❑	❑	
Smoker	❑	❑	
Allergies	❑	❑	

Height ____________

Weight ____________

ACTIVITY LEVEL:

- ❑ Are you a high competitive sports person?
- ❑ Are you well-trained and frequently sporting?
- ❑ Sporting sometimes
- ❑ Non-sporting