

Patient Name: _____

SECTION 3 | SOCIAL & MEDICAL HISTORY

Waist Circumference
Your doctor to record waist measurement at the initial consultation on this form and in patient chart.

What is your height? What is your weight?

Marital Status Single Married De-facto Widowed Separated

Accommodation Home Owner Rental Relatives Home Nursing Home Homeless Other

Live with Spouse Alone Relative/Parents Friend Other

Do you have a carer? Yes No Name & phone of carer:

Please list any significant medical or surgical history

Current Medications

Allergies

Complementary Medications
(e.g. Multivitamins, fish oil)

Note for parents/carers of children - please ignore irrelevant questions (e.g. Smoking, alcohol)

Do you smoke? Yes No If yes, how many cigarettes do you smoke per day? Year started?

Past smoking history? Nil Light Moderate Heavy Year stopped smoking

Do you drink alcohol? Yes No

If yes, how many standard drinks per day? How many days per week?

Have you had a skin check before? Yes No If yes, when?

Do you work / spend a lot of time outdoors? Yes No Do you have a family history of skin cancer? Yes No

Family History Unknown (e.g. Adopted) No significant family history

Mother: Still Alive Yes No If no, age at death Cause of death

Diabetes High Blood Pressure Heart Attack Stroke Colon Cancer Depression
 Breast Cancer Other

Father: Still Alive Yes No If no, age at death Cause of death

Diabetes High Blood Pressure Heart Attack Stroke Colon Cancer Depression
 Prostate Cancer Other

Female Patients: Are you pregnant? Yes No **Have you had a pap smear?** Yes No Month/Year

Are you breast feeding? Yes No **Have you ever had a mammogram?** Yes No Month/Year

Patient Name: _____

Other immediate family member's significant medical history (please specify)

Is there anything else you would like us to know?

SECTION 5 | PARENTING DETAILS (Fill out this section if the new patient is a child)

Are there currently any court orders in place around custody of this child? Yes No
If yes, please provide a brief summary:

To ensure the best protection of the child, we may ask you to provide evidence of court orders, agreements or parenting plans. It is your responsibility to inform us if authorisation for an individual is to be revoked or changed.

Your Privacy. We take the privacy of your personal information very seriously. We are collecting this information in order to provide you with high quality health services. We understand the personal and sensitive nature of the information you are providing to us and will safeguard your privacy in strict accordance with the Privacy Act (1988). If you would like to obtain a copy of our privacy policy or have any questions or concerns, please see our reception staff or our Practice Manager.

SECTION 6 | CONSENT

- I consent to the use of my personal health information by Saltwater Medical and other health care providers involved in my medical treatment and healthcare within this medical centre.
- I consent to the disclosure of my personal health information by Saltwater Medical to other health care providers (external to Saltwater Medical) who are involved in my personal health care or medical treatment (e.g. Specialists, Hospital Services, Allied Health, Pathology, Imaging etc.).
- I consent to receiving reminders, recalls, and appointment confirmations relating to me/my child via SMS, phone call or letter to the contact details listed on this form.
- I consent to Saltwater Medical providing de-identified statistical health information relating to me/my child for the purposes of research and quality assurance activities. Please be assured that your personal details such as name, address and date of birth are NOT disclosed.
- I understand it is my responsibility to inform Saltwater Medical if I have changed address or contact details, have received an updated Medicare card, or if custody arrangements or my health status has changed.
- 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 having a third party (e.g. interpreter or support person) present if required by me in consultations with the doctor.
- I have read the information above and understand the reasons why my personal information is being collected. I understand this practice has a privacy policy on handling patients' information and that I am not obliged to provide any of the information requested, but that failure to do so might compromise the quality of healthcare and treatment provided to me.
- I understand that Saltwater Medical will not contact me after I have been for a test or scan if the result was normal, and that the only time I will be contacted after a test or scan is when there is an abnormal result. I understand that it is my responsibility to arrange a follow up appointment after a test or scan if I am still experiencing symptoms or issues.

Signature

Date

Some things deserve more time and attention. *We believe your health is one of them.*



7 Fourth Avenue Caloundra QLD 4551
T (07) 5301 9828 F (07) 5329 4604
www.saltwatermedical.com.au

