HEIDELBERG WEST MEDICAL

Title: _____

First Name: _____Surname:_____

Date Of Birth: _____ ____ Gender:_____

Patient Address: _____

Phone: _____ Mobile:_____ Email_____ _____

Occupation: _____ Ethnicity / Nationality: _____

Medicare #: _____ IRN: _____ Expiry: _____

Are you of Aboriginal or Torres strait islander origin? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ De-facto

I permit Heidelberg West Medical to contact me via SMS ☐ Yes ☐ No

I permit Heidelberg West Medical to contact me via E-mail ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Details: _____ Work Phone: _____

NEXT OF KIN CONTACT

Name: _____ Relationship: _____

Contact Details: _____ Work Phone: _____

Do you hold any of the below cards? If so please provide details

☐ Centrelink Health Care Card
☐ Centrelink Pension Card
☐ Centrelink Senior Health Card
☐ Dept. of Veteran Affairs (DVA) Gold Card

Card Number :_____

Expiry : _____

I understand that Heidelberg West Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Heidelberg West Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent to Heidelberg West Medical to use and disclose my personal information (except when legal obligations must be met).

Patient Signature: _____

How did you hear about us? ☐ Family ☐ Friend ☐ Google ☐ Hotdoc ☐ Health Engine ☐ Facebook ☐ Instagram ☐ Other: _____

Do you know about My Health Record? ☐ Yes ☐ No (If not, please ask our friendly reception staff)

Would you like our Clinical/Admin staff to register you for My Health Record ☐ Yes ☐ No
(Please ask a form to fill out from Reception)

NEW PATIENT REGISTRATION FORM

HEALTH GROUP

Shop 2/15, 15-23 The Mall (1C), Bell Street
Heidelberg West VIC 3081

P: (+61) 3 9458 1371
F: (+61) 3 9458 1379
hwmedical.com.au

HEIDELBERG WEST MEDICAL

Seen by Doctor _____

Scanned ☐

ONCE COMPLETED PLEASE HAND THIS FORM IN TO YOUR DOCTOR

Patient Name: _____ Date Of Birth: _____

What medical concerns do you wish to discuss with your doctor today?

_____

Past Medical History: Have you suffered from any of the following – currently or previously, what year?

- ☐ Heart Problems
- ☐ Epilepsy
- ☐ Back Pain
- ☐ Liver Disease
- ☐ HIV
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Anxiety / Depression
- ☐ Eye Problems
- ☐ Kidney Disease
- ☐ Other: _____
- ☐ Hep B
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Hep C
- ☐ Fractures
- ☐ Glaucoma
- ☐ Diabetes

ALL

- ☐ Bowel Screening

Date: _____

- ☐ Skin Check

Date: _____

- ☐ Unintended Weight Change

Date: _____

FEMALE

- ☐ Pap smear

Date: _____

- ☐ Mammogram

Date: _____

- ☐ Health Check

Date: _____

Immunisations: _____

MALE

- ☐ Prostate Check

Date: _____

- ☐ Testis Check

Date: _____

- ☐ Health Check

Date: _____

Immunisations: _____

ANY ILLNESSES, OPERATIONS, HOSPITAL ADMISSIONS

Medications and Social History: Please include ALL tablets, inhalers, patches, gels or injections – as well as any other "natural" remedies or supplements

MEDICATION	DOSE	FREQUENCY

- ☐ Smoker
- Per Day: _____
- Start Date: _____
- ☐ Used to Smoke
- Quit in: _____
- ☐ Non-Smoker

- ☐ Alcohol
- Per Week: _____
- Drinks Per Day: _____
- ☐ Rec. Drugs
- Specify: _____
- ☐ Non-Drinker

FAMILY HISTORY	MOTHER ALIVE (Y/N)	FATHER ALIVE (Y/N)	SIBLINGS
Heart Attack	☐	☐	☐
Bowel Cancer	☐	☐	☐
Breast Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐
Arthritis - Osteoarthritis/Rheumatoid?	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐
Hemochromatosis	☐	☐	☐
Osteoporosis	☐	☐	☐
Other	☐	☐	☐

ALLERGIES

The Information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge.

Patient Signature: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY QUESTIONS

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