MEDICAL HISTORY

PATIENT NAME: …… DATE OF BIRTH: ……

Our practice provides our patients with preventive care and early case detection reminders
e.g.: - immunisations, annual health checks; skin checks and pap smears.
Do you offer consent to participate? Yes ❑ No ❑

Would you like your GP to upload a Shared Health Summary of your visit your MyGov Account? Yes ❑ No ❑

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

Aboriginal: Yes ❑ No ❑	Torres Strait Islander: Yes ❑ No ❑	Aboriginal & Torres Strait Islander:

Important Medical History eg chronic diseases, cardiac, cancer etc	Please list:
Do you have any Allergies to medications or wound dressings?	Yes ❑ No ❑ Nil known ❑ If yes please list:

SOCIAL HISTORY

Marital Status:	❑ Single ❑ Married ❑ DeFacto ❑ Separated/divorced ❑ Widow/er
Do you identify as LGBTIQA?	❑ Yes ❑ No If yes please indicate: _____
Are you an Elite Athlete? Do you have an Advanced Care Directive in place? Do you have a Carer? Current Occupation Australian Defence Force	❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No _____ ❑ Current Permanent ❑ Current Reserves ❑ Past Permanent or Reserves
Alcohol: Past Alcohol Intake	❑ Non-Drinker ❑ Drinker: ❑ Beer ❑ wine ❑ spirits How many days per week: _____ Number of standard drinks per day: _____ ❑ Occasional ❑ Moderate ❑ Heavy Year started: _____ Stopped: _____
Tobacco:	❑ Non Smoker ❑ Ex Smoker Year started: _____ Year stopped: _____ ❑ Light ❑ Heavy ❑ Moderate ❑ Smoker: type ie cigarettes, pipe _____year started: _____ amount per day:_____ Recreational Drug use: _____ (type and frequency)

FAMILY HISTORY

Mother still alive:	❑ Yes ❑	No: Age at death: _____	reason of death:	
Father still alive:	❑ Yes ❑	No: Age at death: _____	reason of death:	
Mother:	❑ Diabetes	❑ Hypertension	❑ Heart disease	❑ Stroke
	❑ Colon cancer	❑ Depression	❑ Breast cancer	
Father:	❑ Diabetes	❑ Hypertension	❑ Heart disease	❑ Stroke
	❑ Colon cancer	❑ Depression	❑ Breast cancer	
Ladies: When did you last have a	Pap smear:	Date _____	❑ not sure	❑ never
	Breast Check:	Date _____	❑ not sure	❑ never
	Mammogram:	Date _____	❑ not sure	❑ never

please turn over

Men: When did you last have a -	Full check up: Date _____ ❑ not sure ❑ never
For those 65 years and older	when was the last time you were immunised for ? Influenza: Date _____ ❑ not sure ❑ never Pneumococcal: Date _____ ❑ not sure ❑ never

Is there any other information that you believe we should know that may affect / or have an influence on the medical treatment / advice you will be provided with?
If Yes, please provide details below -

_____

_____

_____

_____

Signature: ……..…… Date: ..... / ..... / .....

Thank you for your cooperation and please return your completed from to your GP.

PATIENT REGISTRATION

This information remains strictly confidential and will not be shared with a third party unless for the immediate purposes of providing healthcare, instructions by a court of law, prevention of a serious threat to a person's life, or with your written consent. Please see our privacy policy for more details.

Title	Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Other:		
Pronoun	She/Her/Hers ❑ He/Him/His ❑ They/Them/Theirs ❑		
Surname		First Name:	Preferred:
Date of Birth			
Street Address			
Postal Address			
Phone	Home:	Mobile:	Work:
Email			
Occupation			
Medicare Number		Ref No.	Expiry:
DVA	Gold ❑ White ❑	Number:	
Centrelink	Pension Number: Expiry:	Health Care Card Number: Expiry:	

Next of Kin		Relationship:
Phone		
Emergency Contact		Relationship:
Phone		

Nationality		Do you require a translator? Yes ❑ No ❑

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

Aboriginal: Yes ❑ No ❑	Torres Strait Islander: Yes ❑ No ❑	Aboriginal & Torres Strait Islander:
Are you an Interstate or Overseas visitor to Adelaide?	Yes ❑ No ❑ *if yes please note full fee is payable today for your consult	
Do you intend to have ongoing medical care provided by O'Halloran Medical Centre? Yes ❑ No ❑		

Do you consent for us to send sms for: appointments, test result recalls, upcoming preventive medicine reminders such as pap smears & health checks?	Yes ❑ No ❑
Do you consent to upload an ehealth summary to your MyGov account?	Yes ❑ No ❑
Do you consent for the clinic staff to use a 3rd party, de-identified AI program for the recording of clinical notes	Yes ❑ No ❑

Do you wish to nominate another person who we can speak to on your behalf regarding upcoming appointments or your medical care? Yes ❑ No ❑		
If Yes	Name:	Relationship:

Office Use Only. Dr: _____ Staff: _____ Nurse: _____

please turn over