Box Hill Family Clinic - 36 Rutland Rd/420 Elgar Rd, Box Hill VIC 3128

This complete medical history is important for you to obtain good health care. Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down. As you are providing us with health information please also read and signs a consent form to allow us to collect and use your health information.

Personal Details

Surname: _____ First Name: _____ M / F DOB: ___ / ___ / _____

Address: _____ Post code: _____

Are you Aboriginal or Torres Strait Islander? Yes / No

Do you have a Centrelink Concessions Card? No/ Yes, Card Number:_____

Marital Status (circle): Single, Married, Separated, Divorced, De Facto, Widowed

Do you have any kid? ☐NO ☐Yes, ____

Contact Number: (Home) _____(Work) _____(Mobile) _____

Country of Birth: _____ Year of Arrival in Australia: _____

Medicare card No: _____ (____) Expire date: _____

Next of Kin (Name): _____

Relationship to you: _____ Phone Number: _____

Emergency contact: ☐Same as above If not : Name:_____ Phone Number:_____

Height: _____ (cm) Weight_____ (Kg)

Current Occupation: _____or School_____ Year_____

Other family members attending this practice: _____

Any custody issues? _____

Medical History

Do you have any allergies to medicine or anything else? Nil known □ Yes □

To what? _____ Reaction_____

Social History	Yes	No	Used to	
• Cigarette	□	□	□	___ cigarettes/day
• Alcohol	□	□	□	____ days/week
• Intravenous drugs	□	□	□	_____
• Other drugs (e.g. marijuana)	□	□	□	_____

Family History:

Has anyone related to you ever had:	Relationship to you	Ever had this (X)	Age of onset	Died from this (X)	Age (now)
High blood pressure					
High cholesterol					
Heart attack/angina					
Stroke					
Asthma /COAD					
Diabetes					
Tuberculosis					
Kidney disease					
Cancer or tumor					
Other					

Patient 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 though 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 eg 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.

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.	

*Patients Name_____ Date_____/_____/_____

*Patient's signature_____

Signed as Guardian for child_____ Name (printed) _____