McLeod Street
MEDICAL

67 McLeod Street
Cairns 4870
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**This information is private and confidential and is for use in your clinical file only**
**NEW PATIENT DETAILS - Please print and give as much detail as possible to assist us in providing quality care.**

**Title**: Mr / Mrs / Ms / Miss / Mast / Dr (please circle) **Gender:** Male / Female / Other (please circle)

**Marital Status:** Single Married De-facto Divorced Widowed Separated

**Surname**: _____ **First Name**: _____ **Middle Name** _____

**Preferred Name**: _____ **Date of Birth** _____/_____/_____

**Residential Address:** _____

**Town/Suburb:** _____ **Postcode:** _____ **Home Phone:** _____

**Mobile:** _____ **Work Phone:** _____

**Postal Address:** (if different to home) _____

**Email Address:** _____@_____ **Do you consent to SMS reminders: Yes / No**
Please note: Email correspondence is not encrypted

**Do You Identify as being-** Aboriginal/Torres Strait Islander/Aboriginal Torres Strait Islander/ Papua New Guinean

**Country of Birth**_____ **Cultural Background** _____

**Is English your first language?** Yes/ No If not, do you require an interpreter? Yes/No

**Occupation** _____ Employed / Self Employed / Unemployed / Retired / Student

**Medicare Number:** _____ **Ref no** _____ (next to name) **Expiry Date:** _____/____

**Vet Affairs No.**_____ **Expiry Date:**_____

**Pension/Healthcare Card Number.**_____ **Expiry Date:**_____

**Do you have a private health care fund? Yes / No Fund** _____ **Number** _____

**Next of Kin:** _____ **Relationship:**_____ **Contact Number:**_____

**Emergency Contact:** _____ **Relationship:** _____

**Contact Number:** (If different from Next of Kin) _____

As part of preventative health services offered by this practice we send out secure reminders and recalls to your mobile phone when routine investigations are due. If you do not have a mobile phone number, please bring this to the attention of a receptionist.
I **consent / do not consent** to receive follow up reminders and recalls to be sent to my mobile phone.(please circle)

McLeod Street Medical is a teaching practice which may mean a student is present during your consultation. If you do not want this please advise your doctor at the time.
McLeod Street Medical participates in the uploading of health information to My Health Record. For More information go to www.myhealthrecord.gov.au

Signature _____ DATE ----/-----/------

## Patient Health Information (Patient to complete and take into appointment)

**Current Medications and Doses including Vitamins and herbal medicine:**

_____
_____
_____

**Please list any known allergies and your reactions e.g. Drugs/ Dressings or list nil known if none:**

_____

**Please list any operations or previous illnesses:**

_____
_____

**Immunisations:** Tetanus: Yes / No/Unknown Date: _____ Hepatitis A & B: Yes / No/Unknown Date: _____

Influenza: Yes/No/Unknown Date: _____ Polio: Yes / No/Unknown Date: _____

**Children's Immunisations – Are they up to date?** Yes / No / Unknown

**SOCIAL HISTORY:** Please circle the most appropriate answer

**Marital Status:** Single Married De-facto Divorced Widowed Separated

**Recreational Activities:** _____

**Does the patient have a Carer:** Yes / No **Carer's Name:** _____

**Address:** _____ **Contact Number:** _____

Do you give consent for us to release results to a designated carer or relative? Relative/Carer name:_____

**Alcohol Consumption:** Do you drink alcohol? Yes / No **If yes days per week _____ Standard drinks per day? _____**

**Do You Smoke?** Yes / No / Never If yes how many per day? _____**Date Ceased:_____**

**Occupation:** _____ Employed / Self Employed / Unemployed / Retired / Student

**MEDICAL HISTORY:** Please circle the most appropriate answer fill out all other areas

**Have you ever had:** Diabetes Kidney Disease Asthma High Blood Pressure
Heart Problems Breast Cancer Colon Cancer Stroke
Depression Epilepsy Other Cancer _____

**Women's Health:** Date of latest Pap Smear _____ Breast Check/Mammogram _____

**Family History:** Unknown (eg Adopted) No significant family history Other – see list below
Kidney Disease Asthma High Blood Pressure Diabetes Heart Problems Epilepsy
Stroke Depression Breast Cancer Colon Cancer Other Cancer _____
**Other immediate family member's significant illness:** _____
_____

**Do you know your blood group?** Yes / No **Blood Group:** _____

If this information is for your child please provide a copy of your child's immunisation history to the nurse.
At McLeod Street Medical we strive to provide high quality care, appropriate to meet our clients health care requirements.
**By becoming a patient of McLeod Street Medical and signing this new patient form I agree and consent to the following:**
I consent to the use of my personal health information by the McLeod Street Medical Team and other health care providers involved in my medical treatment and health care within this centre.
I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.

**Name :**_____ **Signature:** _____ **DOB** _____/_____/_____

**Date:** ___/___/____

# Health Information Collection and Use 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 e.g. notifiable diseases.
- For reminder letters/messages 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. | ☐ |

- **Patient's name:** …… **Date:** ……
- **Patient's signature:** ……
- **Signed as Guardian for child:** ……
  **Name:** (printed) ……