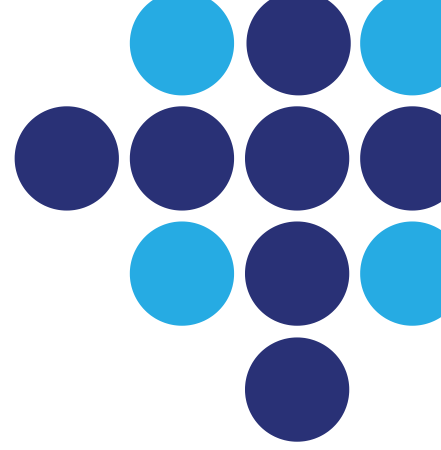


CHELSEA ARCADE MEDICAL



Title: _____

Name: _____

Date Of Birth: _____ Email: _____

Patient Address: _____

Phone: _____ Mobile: _____

Occupation: _____ Gender: _____

Ethnicity / Nationality: _____

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

Marital Status: Single Married Divorced Seperated Widowed
 De-facto

I permit Chelsea Arcade Medical to contact me via SMS Yes No

I permit Chelsea Arcade 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

| | |
|---|-------------|
| <input type="checkbox"/> Centrelink Health Care Card | Card Number |
| <input type="checkbox"/> Centrelink Pension Card | _____ |
| <input type="checkbox"/> Centrelink Senior Health Card | _____ |
| <input type="checkbox"/> Dept. of Veteran Affairs (DVA) Gold Card | Expiry |
| | _____ |

I understand that Chelsea Arcade 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 Chelsea Arcade 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 Chelsea Arcade Medical to use and disclose my personal information (except when legal obligations must be met).

Patient / Guardian 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)



CHELSEA ARCADE 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: Has your child suffered from any of the following – currently or previously, what year?

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Developmental Issues |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fractures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Bronchitis / | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bronchiolitis | |

Has your child had any operations or hospital admissions? Yes No

If Yes, Please provide details

Are your child's immunisations up to date? Yes No

If No, Please provide details

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 |
|------------|------|-----------|
| | | |

FAMILY HISTORY

MOTHER
ALIVE (Y/N)

FATHER
ALIVE (Y/N)

SIBLINGS

ALLERGIES

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--|
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <div style="border: 1px solid black; height: 120px; width: 100%;"></div> |
| Bowel Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthritis - Osteoarthritis/Rheumatoid? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hemochromatosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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

Parent / Guardian Signature: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY QUESTIONS

