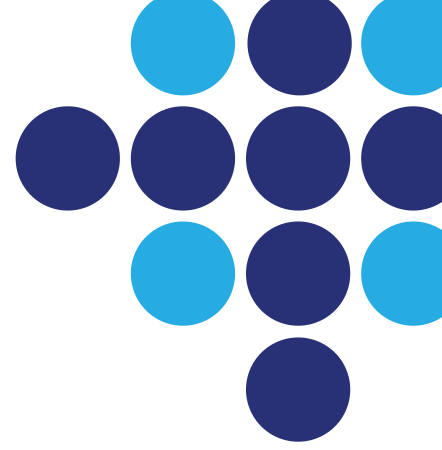


CHELSEA ARCADE MEDICAL



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

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hep C |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hep B | | |

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

ALLERGIES

- Heart Attack
- Bowel Cancer
- Breast Cancer
- High Blood Pressure
- High Cholesterol
- Stroke
- Arthritis - Osteoarthritis/Rheumatoid?
- Diabetes
- Thyroid Disease
- Hemochromatosis
- Osteoporosis
- Other

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: _____

