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HEALTH GROUP

Date Of Birth: Email: Patient Address:					Name:
Patient Address:					
Phone: Mobile: Gender: Occupation: Ethnicity / Nationality: Medicare #: IRN: Expiry: Are you of Aboriginal or Torres strait islander origin? Yes No Marital Status: Single Married Divorced Seperated Widowed De-facto De-facto No No I permit Chelsea Arcade Medical to contact me via SMS Yes No EMERGENCY CONTACT No No Name: Relationship: No Contact Details: Work Phone: No Name: Relationship: Do you hold any of the below cards? If so please provide details Detrelink Health Care Card Centrelink Health Care Card Card Number Centrelink Health Care Card Card Number Dept. of Veteran Affairs (DVA) Gold Card Expiry Indeestand that Chelsea Arcade Medical complies with the privacy and data protection act 2014 and a pair of their privacy public they are committed to privacy of individuals and chelsea Arcade Medical collecting, using, storing and disposing of my presonal information: the release of relevant personal information to the release of relevant personal information and the release of relevant personal information and the release of relevant personal information in therelease of relevant personal information and relevant personal in					
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Name: Relationship: Contact Details: Work Phone: NEXT OF KIN CONTACT Name: Relationship: Contact Details: Work Phone: Contact Details: Work Phone: Do you hold any of the below cards? If so please provide details Centrelink Health Care Card Card Number Centrelink Pension Card Centrelink Senior Health Card Dept. of Veteran Affairs (DVA) Gold Card Expiry Indicates 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 1 how read the above and consent to Chelsea Arcade Medical collecting, up yolks; storing and disposing of my pensonal information, the release of relevant personal information is other health professionals of allowing quality medical care; systems/registers, medical updates and health information and the release of relevant personal information is evice. I understand I may withdraw my consent to Chelsea Arcade Medical 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:		No	E-mail Yes	e Medical to contact me via	I permit Chelsea Arcade
Contact Details:				т	EMERGENCY CONTACT
NEXT OF KIN CONTACT Name:				Relationship:	Name:
Name:				Work Phone:	Contact Details:
Contact Details:				т	NEXT OF KIN CONTACT
Do you hold any of the below cards? If so please provide details Centrelink Health Care Card Card Number Centrelink Pension Card			ship:	Relation	Name:
Centrelink Health Care Card Card Number Centrelink Pension Card Centrelink Senior Health Card Dept. of Veteran Affairs (DVA) Gold Card Expiry 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 notional/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			none:	Work P	Contact Details:
Centrelink Pension Card Centrelink Senior Health Card Dept. of Veteran Affairs (DVA) Gold Card Expiry 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; nclusion 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 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:			ovide details	below cards? If so please p	Do you hold any of the k
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How did you hear about us? Family Friend Google Hotdoc Health Engine Facebook Instagram Other:			tecting the privacy of individuals and I have read the above and consent to sing of my personal information; the ssionals to allow quality medical care i inclusion in national/state reminder and the release of relevant persona epresentative and their insurer in the may withdraw my consent to Chelsed	policy they are committed to pro Ay signature below indicates that llecting, using, storing and dispo- information to other health profe- to be advised of follow up visits updates and health information tive) employer, their authorized ru ultation or service. I understand I u	and as part of their privacy p their personal information. M Chelsea Arcade Medical colli release of relevant personal ir inclusion in a recall register systems/registers, medical up information to my (prospecti case of a work related consul Arcade Medical to use and d
Facebook Instagram Other:				nature:	Patient / Guardian Signa
Do you know about My Health Record? 🛛 Yes 📄 No (If not, please ask our friendly reception	Health Engine	tdoc			How did you hear about
	lly reception sta	our friendly	No (If not, please ask	Health Record? Yes	Do you know about My
Would you like our Clinical/Admin staff to register you for My Health Record Yes No (<i>Please ask a form to fill out from Reception</i>)	No	Yes	you for My Health Record		



CHELSEA ARCADE MEDICAL

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?

Bowel Screening Pap smear Prostate Check Man Date: Date: Date: Date: Man Skin Check Mammogram Testis Check Date: Date: Man Date: Date: Date: Date: Date: Man Unintended Health Check Health Check Health Check Meant Date: Immunisations: Immunisations: Immunisations: Immunisations: Date: Immunisations: Immunisations: Immunisations: Immunisations: Medications and Social History: Please include ALL tablets, inhalers, patches, gels or injections – as well as any other "natural" remedies or supplements Smoker Per Day: Per Start Date:	Heart Problems Epilepsy Back Pain Liver Disease HIV High Cholesterol	Stroke Anxiety / Depression Eye Problems Kidney Disease Other: Hep B	 High Blood Pressure Asthma Thyroid Problems Osteoporosis Blood Clots 	Bronchitis Hep C Fractures Glaucoma Diabetes
Bowel Screening Pap smear Prostate Check Ho Date: Date: Date: Date: ADI Skin Check Mammogram Testis Check Date: ADI Date: Date: Date: Date: Date: ADI Unintended Health Check Health Check Health Check Health Check Health Check Date: Date: Date: Immunisations: Immunisation: Immunisation: Immunisation: Immunisation: Immu				ANY ILLNESSES, OPERATIONS,
Skin Check Mammogram Testis Check Date: Date: Date: Unintended Health Check Health Check Weight Date: Date: Date: Date: Date: Date: Immunisations: Immunisations: 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 MEDICATION DOSE FREQUENCY Smoker Quit in: Start Date: Dr Used to Smoke Quit in: Sp Heart Attack HortHER FATHER SIBLINCS Bowel Cancer High Blood Pressure High Blood Pressure High Blood Pressure High Blood Pressure High Blood Pressure High Cholesterol The Inform The Inform Stroke Disease Disease Disease The Inform Thyroid Disease Disease Disease Disease The Inform Osteoporosis Disease Disease Disease Disease <td></td> <td colspan="2"></td> <td>HOSPITAL</td>				HOSPITAL
Date: Date: Date: Date: Unintended Health Check Health Check Weight Date: Date: Date: Date: Immunisations: Immunisations: Immunisations: Date: Immunisations: Immunisations: Immunisations: Medications and Social History: Please include ALL tablets, inhalers, patches, gels or injections - as well as any other "natural" remedies or supplements 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 Very Day: Per Day: Per Day: Per Day: Per Start Date: Drink Used to Smoke Quit in: Start Date: Drink Start Date: Drink Very Mother FATHER SIBLINGS A Heart Attack Date: Date: Drink Drink Bowel Cancer Date: Date: Date: Drink Drink High Blood Pressure High Cholesterol Drink Drink Drink Drink Drink Drink Osteoarthritis- Drish				
Unintended Weight Change Health Check Health Check Date: Date: Date: Date: Date: Immunisations: Immunisations: Immunisations: 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 Immunisations: Per Day: Per Day: Per Start Date: Dr Used to Smoker Immunisations: Immunisations: Immunisations: Immunisations: FAMILY HISTORY MOTHER ALIVE (Y/N) FATHER ALIVE (Y/N) SIBLINGS A Heart Attack Immunisation: Immunisation: Immunisation: Immunisation: Breast Cancer Immunisation: Immunisation: Immunisation: Immunisation: Immunisation: High Blood Pressure Immunisation: Immunisation: Immunisation: Immunisation: Immunisation: Immunisation: Stroke Immunisation: Immunisation: Immunisation: Immunisation: Immunisation: Immunisation: Stroke Immunisation: Immunisation: Immunisation:<				
Weight Change Date: Date: Date: Immunisations: Immunisations: Date: Immunisations: Immunisations: 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 MEDICATION DOSE FREQUENCY Smoker Quit in: Start Date: Drester Quit in: Start Date: Drester Quit in: Non-Smoker Rester FAMILY HISTORY MOTHER FATHER ALIVE (Y/N) SIBLINGS A Heart Attack				
Date: Immunisations: Immunisations:	Weight			
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: Per Image: Start Date: Image	Change	Date:	Date:	
or injections – as well as any other "natural" remedies or supplements MEDICATION DOSE FREQUENCY Smoker Per Day: Pet Start Date: Dr Start Date:	Date:	Immunisations:	_ Immunisations:	
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FAMILY HISTORY MOTHER FATHER SIBLINGS A Heart Attack ALIVE (Y/N) ALIVE (Y/N) SIBLINGS A Bowel Cancer Breast Cancer A A A A High Blood Pressure A A A A A A Stroke A A A A A A A A Diabetes A A A A A A A A A A A Osteoprosis A <t< td=""><td></td><td></td><td></td><td></td></t<>				
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ALIVE (Y/N) ALIVE (Y/N)			Non-Smoker	Non-Drinker
Bowel Cancer Breast Cancer High Blood Pressure High Cholesterol Stroke Arthritis - Osteoarthritis/Rheumatoid? Diabetes Thyroid Disease Hemochromatosis Osteoporosis	FAMILY HISTORY			ALLERGIES
Other major omi	Bowel Cancer Breast Cancer High Blood Pressure High Cholesterol Stroke Arthritis - Osteoarthritis/Rheuma Diabetes Thyroid Disease Hemochromatosis Osteoporosis	toid?	in t con maj	Information I have provided his questionnaire is correct, plete and without any ior omissions to the best of knowledge.

CONFIDENTIAL MEDICAL HISTORY QUESTIONS

HEALTH GROUP

Parent / Guardian Signature: ___ Date:

> Shop 10 & 11, 426 Nepean, Hwy, Chelsea VIC 3196

P: (+61) 3 9772 9878 F: (+61) 3 9772 0897 camedical.com.au

Seen by Doctor Scanned