811. Patient Questionnaire, full summary

We need this information to provide best quality care. Our practice follows the guidelines of the Royal Australian College of General Practice for the management of health information which will be kept private and secure as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with your GP.

Mr Mrs Ms Miss Master

Surname: …………………………….. **First names:** …………….…… ……….……….

Date of birth: ……………………….Male/Female: ………………………….……..…….

Address: Number and Street: ……………………………………….……….…..……

Suburb: ……………………………… Postcode: …………………………

Telephone: Home……………………Work…………………….Mobile…………………

Are you of Aboriginal or Torres Strait Islander origin?

No …………….
Yes, Aboriginal …………..
Yes, Torres Strait Islander ……………………..
Yes Both Aboriginal and Torres Strait Islander ………………………

Australia is a multi-cultural society and so we can provide the most appropriate health care for our patients please tell us your cultural background or ethnicity:

……………………………………………………..

Medicare Number: ……………………………Exp:…………. Card Ref No: …………

IHI: ……………………………………………..

Health Care Card Number: ……………………………………Exp:……………………

Pension Number: ………………………………………………………………………..

Veterans Affairs Number: ………………………………………………………………

Emergency contact

Name: ……………………….....................Relationship to you………………………..…

Telephone: home……………………work……………………mobile……………………

<u>Next of Kin</u>*: (if different from Emergency Contact Person)*

Name: ………………………....................Relationship to you…………………………..…

Telephone: home……………………work……………………mobile……………………

Do you have a My Health Record ? Yes…....No……Unsure……..

Immunisations

Year of last immunisations if known

Pneumococcal	……………………..……………………………..
Influenza	……………………………………..………..
ADT (adult diphtheria and tetanus)	……………………..……………………………..
Travel Vaccines	………………………………………………
Others………………………………	…………………………..…………………..
………………………………	…………………………..…………………..

Allergic reactions (or side effects to medications or other things)

Medications / other things	Side effects
…………………………..…	………………………….……………
…………………………..…	………………………..………………
…………………………..…	………………………..………...…..….
…………………………..…	…………………………..…………

Name of pharmacy that dispenses your medications:

……………………………………………………………………………………………

Medications taken

Name of medication	Dose	Number of times taken each day
…………………….	……..	……………………………………
…………………….	………	……………………………………
……………………..	………	……………………………………
……………………..	………	……………………………………

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Past surgical history

Underline the operation and enter the year:

Previous operation	Year
○ Tonsils removed	………
○ Adenoids removed	………
○ Appendix removed	………
○ Inguinal hernia repair	………
○ Umbilical hernia repair	………
○ Hysterectomy	………
○ Gallbladder removed	………
○ Caesarian section	………
○ Other operations	………
○ ……………………..	………

Past medical history

Underline the disease and enter the year:

Disease or illness	Year diagnosed	Disease or illness	Year diagnosed
• Rheumatic fever	……....	Glandular fever	………
• High blood pressure	……..	Diabetes	………
• Hepatitis	……...	High cholesterol	……….
• Fits or epilepsy	……....	Asthma	…….....
• Tuberculosis	……..	Gout	……….
• Heart problems	……..	Kidney stones	……….
• Kidney infections	……...	Stomach ulcers	…….....
• Duodenal ulcer	……....	Gastric reflux	………
• Cancer	………	Anxiety attacks	………
• Depression	………	Other problems	………
• Osteoarthritis	…….....		

Social History

Marital Status: Married Widowed Single Separated Divorced Partner

Names of children (if any, *optional*) Phone number.

…………………………………… …………………………………………………

…………………………………… …………………………………………………

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…………………………………… …………………………………………………

…………………………………… …………………………………………………

Are you a <u>smoker</u>? .... If yes how many per day? ....

Ex-smoker – how many per day? ....Quit date ……………………………

Do you drink <u>alcohol</u>? ……..…. How many per day? ……… or per week? ………..…

Are you concerned by your drinking? ……………………………………………………

<u>Occupation/s</u> (Present and past)

………………………………………………………………………………………..

Now retired? Yes ……….No….……

On disability support pension? Yes……….No….……

<u>Family history</u> –

Please enter any health problems that your relatives may have, and if deceased, the cause of death and age when deceased.

Mother ……………………………………………………………………….……

Father ……………………………………………………………………..………

Brother/s ………………………………………………………………………..…

……………………………………………………………………………

……………………………………………………………………………

Sister/s ……………………………………………………………………...……..

……………………………………………………………………………

……………………………………………………………………………

Consents

Patient name ……………………… dob ……………… Date …………………………

I consent to my personal information being collected. Swansea. This information is collected for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

The information will normally be collected directly from you, however there may be occasions when we will need to obtain information from other sources for eg: other medical practitioners, allied health providers or hospitals. In case of emergency we may need to collect personal information from relatives or other sources where we are unable to obtain your prior consent.

With your consent, the practice staff will use and disclose your information for purposes such as: referral to another medical practitioner/health providers, sending of specimens such as blood samples/skin excisions, referral to a hospital for treatment/advice, to prevent or lessen a serious threat to an individual's life, health or safety, where legally required to do so ie records to court, mandatory reporting of child abuse or notification of diagnosis of a communicable disease, recall/reminder systems, the management of our practice, quality assurance, practice accreditation and complaint handling, to meet any obligations of notification to our medical defence or insurers, to supply results/reports/recommendations to your referred to doctor pertaining to your medical management. **YES / NO**

I consent to receive SMS reminders on my mobile phone. **YES / NO**

I consent for my de-identified data to be shared (de-identified data cannot be traced back to an individual). We occasionally participate in research and quality assurance activities to improve individual, community health care and Practice Management. Examples of where this information can be used are to: improve care, estimate the costs of care and support public health initiatives. If you choose not to participate, it will in no way impact the care you are given at this Practice.
YES / NO

These consents can be changed at any time. Please talk to our staff who will provide you with a new consent form to complete.

Third Party consent

Please tick the appropriate entries on this form if you wish to have a third party act on your behalf for any of the following:

Please tick below if applicable:

____ Making and /or cancelling appointments

____ Take phone calls

____ Receive Results

____ Make and confirm appointments

____ Collect requested letters, scripts etc

____ Make or receive any other enquiries or correspondence from any Doctor, Nurse or administrative staff at Swansea Medical Centre

If I choose to change this I will notify the surgery in writing and I understand that until I receive written confirmation from the surgery that this third party consent will still be in effect.

Third Party Name …………………………………………………………...

Patient Name ……………………………………

Signature…………………………………………… Date: ………………………………