Total Health Pottsville – Adult patient information form

Thank you for completing the following 2 pages:

Title (please circle) **Pronouns** (please circle)	**Mr Mrs Ms Miss Master** **She / Her / Hers**	**Birth M / F Gender M / F / Other** **He / Him / His**	**They / Them / Theirs**
Surname			
First & Second Names		**Preferred Name**	
Date of Birth			
Address **Email:**			
Postal address **(if different to above)**			
Telephone Numbers	**Home:**	**Mobile:**	**Work:**
Medicare Number		**Ref #**	**Expiry Date**
Veterans' Card Number: **Gold / White / Orange** (please circle)			**Expiry Date**
Pension Card Number			**Expiry Date**
Health Care Card Number			**Expiry Date**
Next of Kin	**Name:** **Relationship to you:**	**Phone number:** **Address:**	
Emergency Contact Person **(if different to above)**	**Name:** **Relationship to you:**	**Phone number:** **Address:**	
What is your ethnicity/family heritage/place of birth?			
Do you speak a language other than English?		**Would you like us to arrange a translator?**	
Do you identify as Aboriginal or Torres Strait Islander? (please circle)	**Aboriginal** **Torres Strait Islander** **Other**	**Both Aboriginal & TSI** **Neither Aboriginal nor TSI**	

We contact patients by SMS text message/phone and/or send out recall letters for test results and for ongoing patient care. Doctors at Total Health Pottsville are required to participate in research for quality assurance. To enable us to do this, we need permission to use de-identified medical information from a patient's medical records. Please sign below to give permission to be included in our recall system, and to give permission for your de-identified medical data to be used for research and quality improvement purposes.

Signature:…… **Date:**……..

The **confidentiality of information** contained within this document is protected & will not be used for any purpose other than to create a medical record.

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***PATIENT NAME*:** .....

Height: ..... cm **Weight:** ..... kg

Marital Status (please circle) Single Married De facto Widowed Divorced

Occupation: .....

Any ALLERGIES or sensitivities to medications, dressings or foods? (please circle)

- No
- Yes - Please specify .....

Do you smoke cigarettes? (please circle)

- No, I've never been a regular smoker
- Not now, but I used to smoke
- Yes – how many daily on average? .....

Do you drink alcohol? (please circle)

- Never
- Sometimes (monthly? couple times each year?)
- Weekly – how many days?
- Daily – how many drinks?

Do you have, or have you ever had, any medical problems? (please circle)

- Asthma
- Diabetes
- Heart disease
- Other – please specify .....
- High blood pressure
- High cholesterol
- Depression and/or anxiety

Current medications (including over the counter medications, vitamins & supplements):

1. ..... **3.** ..... **5.** .....

2. ..... **4.** ..... **6.** .....

Cancer screening:

- Patients aged over 40, have you had had a full skin check in the last 12 months? Yes No
- Patients aged 50 to 75, have you undertaken bowel cancer screening in the last 2 years? Yes No
- Ladies aged 20 to 74, when did you last have a screening test for cervical cancer? .....
- Ladies aged 50 to 74, when did you last have a mammogram for breast cancer screening? .....

In your family, does anyone have any medical problems? (please circle)

- Asthma
- Diabetes
- Heart disease
- Depression and/or anxiety
- High blood pressure
- High cholesterol
- Cancer
- Other – please specify .....