



SIR/DR/MR/MRS/MS/MISS/MASTER DRIVER LICENCE NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_ SURNAME: \_\_\_\_\_ KNOWN AS: \_\_\_\_\_

DOB: \_\_\_\_\_ GENDER: \_\_\_\_\_

Do you identify as (Please tick): **ABORIGINAL**  **TORRES STRAIT ISLANDER**  **NON-INDIGENOUS**

MEDICARE NUMBER: \_\_\_\_\_ REF: \_\_\_\_\_ EXPIRY: \_\_\_\_\_

HEALTHCARE /PENSION/DVA/STUDENT CARD NUMBER: \_\_\_\_\_ EXPIRY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SUBURB: \_\_\_\_\_ STATE: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

TELEPHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

COUNTRY OF BIRTH: \_\_\_\_\_ CULTURAL BCKGRND: \_\_\_\_\_

MAIN LANGUAGE SPOKEN AT HOME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

DO YOU NEED AN INTERPRETER? \_\_\_\_\_

HEIGHT: \_\_\_\_\_ CM WEIGHT: \_\_\_\_\_ KG PLEASE ASK NURSE / DOCTOR IF UNSURE

**DRUG ALLERGIES** (PLEASE TICK):  NO  YES, PLEASE SPECIFY: \_\_\_\_\_

NATURE OF REACTION: \_\_\_\_\_ SEVERITY:  MILD  MODERATE  SEVERE  LIFE THREATENING

**OTHER ALLERGIES** (PLEASE TICK):  NO  YES, PLEASE SPECIFY: \_\_\_\_\_

SMOKING HISTORY: (PLEASE CIRCLE) SMOKER EX-SMOKER NEVER SMOKED

CIGARETTES PER DAY \_\_\_\_\_ YEAR COMMENCED \_\_\_\_\_ YEAR QUIT \_\_\_\_\_

HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL: (PLEASE CIRCLE)

NEVER / MONTHLY OR LESS / 2-4 TIMES MONTH / 2-3 TIMES A WEEK / 4 OR MORE TIMES A WEEK

ON THAT OCCASION HOW MANY STANDARD DRINKS CONTAINING ALCOHOL DO YOU HAVE: (PLEASE CIRCLE)

1 OR 2 / 3 OR 4 / 5 OR 6 / 7 TO 9 / 10 OR MORE

HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS CONTAINING ALCOHOL ON ONE OCCASION? (PLEASE CIRCLE)

NEVER / LESS THAN MONTHLY / MONTHLY / WEEKLY / DAILY OR ALMOST DAILY

**DO YOU SUFFER FROM ANY OF THE FOLLOWING?**

	Yes	Year Diagnosed	No		Yes	Year Diagnosed	No
Coronary Heart Disease				Epilepsy			
Stroke				Arthritis			
Lung Cancer				Osteoporosis			
Breast Cancer				Oral Disease			
Any other Cancer				Asthma			
Type 2 Diabetes				Depression & Anxiety			
Chronic Kidney Disease				Chronic Obstructive Pulmonary Disease (COPD)			
High Blood Pressure				Type 1 Diabetes			

FROM THE PREVIOUS LIST, DO ANY OF YOUR IMMEDIATE FAMILY SUFFER FROM - INCLUDE: **THEIR RELATIONSHIP TO YOU & YEAR OF DIAGNOSIS.**



DO YOU HAVE ANY OTHER SIGNIFICANT MEDICAL CONDITIONS? IF SO, PLEASE LIST BELOW WITH YEAR OF DIAGNOSIS?

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD ANY MAJOR SURGERY OR OPERATIONS? IF SO, PLEASE STATE WHAT AND WHEN?

\_\_\_\_\_

\_\_\_\_\_

SOCIAL HISTORY: HOW MANY PEOPLE LIVE WITHIN YOUR HOUSE HOLD: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_

DO YOU LIVE WITH: (PLEASE CIRCLE) PARENTS/PARTNER/CHILDREN/FRIENDS/BY YOURSELF/OTHER

HOW MANY BROTHERS AND SISTERS DO YOU HAVE: BROTHERS \_\_\_\_\_ SISTERS \_\_\_\_\_

EMERGENCY CONTACT DETAILS	NEXT OF KIN CONTACT DETAILS
NAME:	NAME:
RELATION:	RELATION:
PHONE NUMBER:	PHONE NUMBER:

**IN CASE OF EMERGENCY : DO YOU CONSENT FOR YOUR NEXT OF KIN TO ACCESS YOUR MEDICAL RECORDS**

(PLEASE TICK):  NO  YES, PLEASE SPECIFY: \_\_\_\_\_

**IF THE PATIENT IS A CHILD, PLEASE COMPLETE CARER'S DETAILS BELOW:**

SIR/DR/MR/MRS/MS/MISS NAME: \_\_\_\_\_ SURNAME: \_\_\_\_\_

DOB: \_\_\_\_\_ MALE / FEMALE (Please Circle)

MEDICARE NUMBER: \_\_\_\_\_ REF: \_\_\_\_\_ EXPIRY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SUBURB: \_\_\_\_\_ STATE: \_\_\_\_\_ POSTCODE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

**We require your consent to collect information about you. Please read this information carefully, and sign where indicated below**

At this practice, we collect personal information from our patients for the primary purpose of providing quality health care services. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

I have read the information above and been made aware of the privacy policy. I understand the reasons why my information must be collected. I am also aware that this practice has a strict privacy policy on handling patient information.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained. I therefore consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

SIGNED.....DATE.....

PATIENT NAME/PARENT OR GUARDIAN NAME.....

How did you hear about Calamvale Family Practice .....



Calamvale Family Practice  
 18/2605 Beaudesert Rd  
 Calamvale QLD 4116  
 Ph: 07 3272 4533  
 Fx: 07 3272 5815

## Your Information

# It's Private

### What happens to information About you while you are a Consumer of this service?

<p><b>Who Are WE?</b>          We are one of several health and community care services in your area, all working together in partnerships to meet your health needs.</p>	<p><b>What Say Do You Have In What Happens To Your Information?</b>          You have a say in what happens to your information. We rely on the information you give us to help provide the right care for you. If you decide not to share some of your information or restrict access to your consumer record, this is your right, but it may affect our ability to provide you with the best possible services. Talk to us if you wish to change or cancel your consent.</p>
<p><b>What Information Do We Collect About You?</b>          We keep your name and contact details on your patient record. Other details such as your care plan and information about your health are recorded each time you visit.</p>	<p><b>How Will Your Information Be Protected?</b>          We are committed to protecting the confidentiality of your record. The privacy of your information is also protected by law. We treat your information in the strictest confidence and store securely.</p>
<p><b>Why Do We Collect Your Information?</b>          The information we collect helps us to keep up-to-date details about your needs, so we can care for you in the best possible way. We also use the information to better manage and plan this service.</p>	<p><b>Can You Access Your Information?</b>          Yes, you have a right to request access to your information and to ask for it to be corrected if necessary.</p>
<p><b>Who Else Sees Your Information?</b>          Your information can only be seen by the professionals in this service involved in your care. Otherwise, we only release information about you if you agree or if required by law, such as in an emergency.</p>	<p><b>Any Other Questions?</b>          Please talk to one of our staff if you have any other questions or complaints about what happens to your information while you are our patient, or if you wish to access your record.</p>

If you have any other questions our Practice Manager is always happy to speak with you!