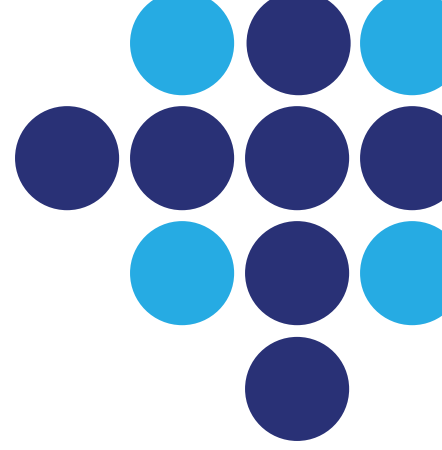


# BALWYN CENTRAL MEDICAL



Title: \_\_\_\_\_  
Name: \_\_\_\_\_  
Date Of Birth: \_\_\_\_\_ Email: \_\_\_\_\_  
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  Separated  Widowed  
 De-facto

I permit Balwyn Central Medical to contact me via SMS  Yes  No

I permit Balwyn Central 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 Balwyn Central 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 Balwyn Central 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 Balwyn Central 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)



# BALWYN CENTRAL MEDICAL

Seen by Doctor \_\_\_\_\_

ONCE COMPLETED PLEASE HAND THIS FORM IN TO YOUR DOCTOR

Scanned

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

What medical concerns do you wish to discuss with your doctor today?

\_\_\_\_\_

Past Medical History: Has your child suffered from any of the following – currently or previously, what year?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Developmental Issues    |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Thyroid Problems    | <input type="checkbox"/> No Past Medical History |
| <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Blood Clots    | <input type="checkbox"/> Asthma              |  |
| <input type="checkbox"/> Eye Problems   | <input type="checkbox"/> Bronchitis /        |  |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bronchiolitis       |  |

Has your child had any operations or hospital admissions?  Yes  No

If Yes, Please provide details

\_\_\_\_\_

Are your child's immunisations up to date?  Yes  No

If No, Please provide details

\_\_\_\_\_

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

## FAMILY HISTORY

MOTHER  
ALIVE (Y/N)

FATHER  
ALIVE (Y/N)

SIBLINGS

ALLERGIES

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| Heart Attack                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel Cancer                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast Cancer                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis -<br>Osteoarthritis/Rheumatoid? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Disease                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemochromatosis                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| No Significant Family History             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*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: \_\_\_\_\_



CONFIDENTIAL MEDICAL HISTORY QUESTIONS