Dr Maclay General Practice

418/530 Little Collins St– Melbourne – 3000
PH 99097540

PERSONAL DETAILS

Title:…… First name:……

Surname:……D.O.B:……/……/……

Address:……

Suburb:……Post Code:……

Tel: H:……M:……

Email:……

SMS Booking Reminder: YES NO

Occupation:……

Marital status:……

Country of Birth:……

Ethnicity/Background:……

Do you or your Family identify as being Aboriginal or Torres Strait Islander? YES NO

MEDICARE DETAILS

Medicare Number:……

Reference Number(in front of name):……Expiry date:……/……

Pension/Centrelink/Senior Card Number:……

Expiry Date:……/……/……..

If DVA, Which: ORANGE WHITE GOLD

ALLERGIES

Are you allergic to any Medication? YES NO

If YES please List:……

EMERGENCY CONTACT:……

Relationship:……Tel:……

Next of Kin (if different from above):……

How did you hear about us? Word of mouth Flyer Internet Newspaper Walked Pass
Other(please specify):……

FAMILY HISTORY

Has any member of your family been diagnosed with diabetes, a heart condition or any form of cancer? If yes please detail:

……

……

PAST MEDICAL HISTORY

Have you been a patient in a hospital, if so for what reason and which year?……

……

Are you diabetic? **YES** **NO** If yes, TYPE 1 OR TYPE 2

When was your last pap smear (women only)? ……

Do you suffer from high blood pressure? **YES** **NO**

Have you ever suffered from chest pain or shortness of breath?

YES **NO**

SOCIAL HISTORY

Do you smoke? **YES** **NO**

If YES, how many per day: ……

Have you previously smoked? **YES** **NO**

If YES, when did you give up smoking? ……

Do you drink alcohol? **YES** **NO**

If YES, how many days per week: ……

PRIVACY AGREEMENT AND PATIENT CONSENT

I understand that this practice complies with the Privacy Act (1998) 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 Docklands Family 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.

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SIGNATURE: ……..

DATE: / /