



**OSHC Students**

**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:.....

**INSURANCE INFORMATION**

Membership/Policy Number:.....  
Insurance Company:.....  
Expiry date: / /

**ALLERGIES**

Are you allergic to any Medication? YES NO  
If YES please List:.....

**EMERGENCY CONTACT.**

Name:.....  
Relationship:.....Tel:.....  
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 Dr Maclay General Practice collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care.

**SIGNATURE:** .....

**DATE:** / /