inclusive health clinic
OVERCOMING HEALTH INEQUALITY

Patient Registration form

Title (please circle)	Mr Ms Mrs Miss Other	
Surname		
First Name		
Middle Name		
Preferred Name		
Date of Birth	____ / ____ / _____	
Gender		
Home Address		
Postal Address (if different to home address)		
Phone Contact	Mobile:	Home/Other:

Do you consent to receiving SMS communications from the Clinic?
SMS may include appt reminders, clinical communications (results and clinical messages) and health awareness communications: (Please circle appropriate Response) **YES** **NO**

Email		
Are you Australian Aboriginal or Torres Strait Islander? (Please circle appropriate Response)	**YES** – Aboriginal	**YES** – Both Aboriginal and TSI
	YES - Torres Strait Islander	**NO** – I am not Australian Indigenous
Medicare Number	Ref No:	Expiry Date
Pension card or HCC (please circle)	Number:	Expiry Date
DVA Gold / White		Expiry Date

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Inclusive Health Partnerships is committed to ensuring that every person, regardless of their circumstances, has access to quality physical, dental, mental health and holistic healthcare services irrespective of their ability to pay.

Funded by
Queensland Government

Next of Kin Relationship to Patient	(Name and Telephone number)
Emergency Contact (If different to Next of Kin)	(Name and Telephone number of a person we can contact if needed)
Private Health Insurance	Fund Membership Number
Nationality / Place of Birth and Language spoken at home (if not English)	
We appreciate you answering these questions, so we can tailor care and encourage appreciation between people from different nationalities and cultural backgrounds.	If your first Language is not English, do you require an interpreter? (Please circle your response) YES (what Language?) _____ NO

Patient consent form

So that we may properly assess, diagnose, treat and be proactive in your health care needs we require you to provide us with your personal details and a full medical history.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use, and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For internal quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but, should information that will identify you be required, you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g., notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management. Please read this consent form carefully, and sign where indicated below.

You can decline to have your health information used in all or some of the ways outlined above and it will not affect the care that you receive at this practice.

	Yes	No
I have read the information above and understand the reasons why my information must be collected.	☐	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐	☐
I understand that the Clinic has expected standards of behaviour and that any aggressive, threatening, violent or abusive behaviours will not be tolerated.	☐	☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐	☐

Patient's name: …… **Date: ____ / ____ / _____**

Patient's signature: ……

Please return the completed form to Reception.

Medical Information

Patient's name: …… **DOB: ____ / ____ / _____**

Family history

	QUESTION	YES	NO
1.	**Have any of your close relatives had heart disease before 60 years of age?** Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery.		
2.	**Have any of your close relative had diabetes?** Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes		
3.	**Do you have any close relatives who has melanoma?**		
4.	**Have any of your close relatives had bowel cancer before 5 years of age?**		
5.	**Do you have more than one relative on the same side of the family who had bowl cancer at any age?** Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.		
6.	**Have any of your close male relatives had prostate cancer before 60 years of age?**		
7.	**Have any of your close relatives had breast cancer before 50 years of age?**		
8.	**Have any of your close relatives had breast cancer before 50 years of age?**		
9.	**Do you have more than one relative on the same side of your family who has had breast cancer at any age?** Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren*		
10.	**Is there a history of mood disorder in your immediate family?**		

If there is a family history of cancer, please specify what kind:	

Lifestyle health history (specify approximate month/year)

Smoking history: ☐ Never smoked ☐ Former smoker, quit date ____ / ____ / _____ ☐ Current smoker ……./day Number of years smoking ……	Alcohol: Do you drink alcohol? ☐yes ☐no Drinks per day …… Drinks per week ……

Women's Health History

Last pap smear date ____ / ____ / _____	Last mammogram date ____ / ____ / _____

Men's Health History

Last prostate check (if aged over 40)	

Infant Profile

Please list any problems during pregnancy:

When was the baby born?	☐ Full Term ☐ Premature – how many weeks? .....
Mode of delivery?	☐ Normal ☐ Caesarean ☐ Forceps ☐ Vacuum extraction
Please list any health problems for the baby after birth	
Feeding	☐ Bottle ☐ Breastfed
Are there any smokers in the household?	☐ yes ☐ no

Medical Information

Patient's name: …… **DOB: ____ / ____ / _____**

Allergies ☐ Nil known

Allergy/intolerances	Reaction	Severity

Please tick any relevant past medical/surgical history

☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes
☐ Cancer
☐ Migraine
☐ Stroke
☐ Blood clots
☐ Asthma
☐ Stomach or duodenal ulcer
☐ Epilepsy
☐ Depression/Anxiety

Other illness/surgery – please give details	

Please list current medications, including vitamins and mineral supplements

Name	Dose	Name	Dose

Immunisations

☐ Pneumococcal (pneumonia)
☐ Influenza
☐ Tetanus
☐ Childhood vaccines up to date
☐ Other (please specify)

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