Open Monday to Friday 9am – 5pm

Kerrie Road
FAMILY MEDICAL CENTRE

Phone: 03 9803 1022
Fax: 03 9803 6041
880 High Street Road

Glen Waverley VIC 3150

New Patient Medical Questionnaire

Full Name:	**Date of Birth: / /**
Occupation:	
Please list all food, drug or other allergies you have:	
Do you have any ongoing medical conditions? ☐ Yes ☐ No	
If yes, please list (include date diagnosed if known):	
Have you had any significant previous health problems? ☐ Yes ☐ No	
If yes, please list (include dates if known):	
Are your parents alive? Mother ☐ Yes ☐ No Father ☐ Yes ☐ No	
Does anyone in your family have a history of serious illnesses? ☐ Yes ☐ No	
If yes, it is: ☐ Heart Disease? ☐ Diabetes? ☐ Cancer? ☐ Hypertension? ☐ Other:	
What relation is this person to you? ☐ Mother ☐Father ☐Brother ☐Sister ☐Grandmother ☐Grandfather	
Please list all medications you currently take:	
Do you smoke cigarettes or cigars? ☐ Yes ☐ No	
If yes, how many per day? What year did you start smoking? What year did you quit?	
Do you drink alcohol? ☐ Yes ☐ No	
If yes, what quantity per week?	
When did you last have these immunisations? **Influenza Date:** **Pneumonia Date:** **Tetanus / Whopping Cough Date:**	

Women's Health:	***Men's Health:***
When was your last cervical screening? (if relevant) **Date if known:** **Result if known:** **Within last 12 months ☐** **Within last 2 years ☐** **More than 2 years ago ☐** **More than 4 years ago ☐** **Never ☐** **Not required ☐**	**When was your last prostate check?** **Date if known:** **Result if known:** **Within last 12 months ☐** **Within last 2 years ☐** **More than 2 years ago ☐** **More than 4 years ago ☐** **Never ☐** **Not required ☐**

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We Care for Your Health.

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

Kerrie Road Family Medical Centre collect information from you for the primary purpose of providing quality health care. 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 healthcare needs. This means we will use the information you provide us in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare Australia requirements.
- Disclose to others involved in your healthcare, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- To contact you or your family for the purposes of Recalls & Reminders

Patient information shall not be released to a third party without the expressed consent of the patient.

- I have read the information above and understand the reasons why my information is collected.
- I understand that I am not obliged to provide any information requested of me, but failure to do so might compromise the quality of the healthcare and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purposes other than set out above, my further consent will be obtained.
- I consent to the handling of my information by this practice for the purpose set out above.

Full Name: _____ Date: _____/_____/_____

Signature: _____