

HEALTH SUMMARY



Title Mr Ms Mrs Mast Miss Dr (please circle)			
Surname:		Given Name:	
Address:			
Home:		Mobile:	Gender: Male / Female
Date of Birth:	Email:	Occupation: (incl. home duties/ student/ child)	
Country of birth:		Ethnicity:	
Aboriginal	Torres Strait Islander		Neither (please circle if applicable)
Emergency Contact:			
Name:			
Number:			
Relationship to patient:			
Medicare No.		Ref. _____	Expiry ____/____
DVA No		_____	Expiry ____/____
Health / Pensioners Card (please circle)		_____	Expiry ____/____
Private Health Insurance (company, type of cover, extras):			
BASIC	INTERMEDIATE	TOP	(please circle)
Social/Family Structure		Marital status:	
Who lives at home with you?		No. of children:	
Are there any existing court orders on children 17 years and under? YES / NO (please circle)		No. of brothers or sisters you have:	

Previous General Practitioner:

Address:

Last seen on:

Phone:

(If you wish to transfer your records to our clinic, please fill in our transfer form)

Allergies (if any):

Do you drink alcohol?

How often do you have a drink containing alcohol? Never / Monthly or less / 2-4 times a month
2-3 times a week / 4 or more times a week

How many standard drinks do you have on a typical day? 1 or 2 / 3 or 4 / 5 or 6 / 7 or 9 / 10 or more

How often do you have six or more drinks on one occasion? Never / Less than monthly / Monthly
Weekly / Daily or almost daily

If not, have you ever been a drinker? (if so when):

Do you smoke? YES / NO (please circle)

If so, how many do you smoke per day:

If not, have you ever been a smoker? (if so when):

Past Medical History:

Have you had any operations? Please list type & approximate date:

Do you have any of the following conditions / diseases (please tick all that apply) :

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Abnormal pap smear |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dermatitis/Eczema | <input type="checkbox"/> Cancer of any type |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eye condition | <input type="checkbox"/> Dementia | |
| <input type="checkbox"/> Coeliac disease | <input type="checkbox"/> Migraines | Any other conditions: |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Seizures or fits | |

Immunisations: Up to date with childhood immunisations: (where applicable)

YES / NO (please circle)

Travel vaccines received:

Current Medications

Prescriptions:

Over the counter :

Herbal :

Activity

What form of activity do you do each week? eg. walking, golf, gardening. How many days per week do you do each?

Do you ever experience any of the following during or after exercise? Breathlessness Cough Wheeze
Chest pain Dizziness (please circle)

Family History

Do you have a family history (including parents/siblings/extended family) of any of the following: (circle all that apply)

High blood pressure High cholesterol Heart disease Stroke Cancer Eye condition Diabetes
Blood disorder Asthma Eczema Mental Health

Any other conditions:

Women's Health (as appropriate)

When was your last pap smear?

Was it: Normal Abnormal Not sure (please circle)

When was your last mammogram?

Was it: Normal Abnormal Not sure (please circle)

Is there a family history of breast cancer? Mother Sister Other relative (please circle)

Are you pregnant currently? YES / NO (please circle)

Men's Health (as appropriate)

When was the last time you had a prostate examination?

Never Can't Remember _____ Years ago

Was it: Normal Abnormal Not sure (please circle)

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders:
e.g. immunisations, annual health checks, skin checks and pap smears.

I agree to have any relevant health reminders sent to me. I agree to receive SMS contact/reminders from the surgery.
This may include test results.

Who completed this form?: SELF / OTHER (please circle)

If other, name, phone no. and relationship to patient:

Signature: _____ **Date:** _____

PATIENT FILE TRANSFER REQUEST

Please complete if you wish to continue your health care at this clinic

To: Dr.

Address:

.....

Fax No:

Re:

D.O.B:

Address:

.....

Additional family members to be transferred: (over 18's signature required)

..... D.O.B:

..... D.O.B:

..... D.O.B:

The above named patient has elected to attend Durrant Medical Clinic for future medical care.

As we are a paperless clinic, please forward a copy patient's medical history, including specialist reports, relevant investigations and treatments.

- We prefer history sent via:
- 1) Argus argus@durrantmc.com.au
 - 2) If you use Medical Director MD3 supply disk as .xml file.
 - 3) If you use a different medical programme eg: Best Practice, Genie etc - supply disk as .html file.
 - 4) By fax – **DO NOT POST ANY PAPER FILES**

The patient has signed an authority requesting you to release this information.

Yours faithfully,

Durrant Medical Clinic

-----**Patient Authority**-----

Please forward all relevant medical records relating to the above mentioned patient to Durrant Medical, 29 Durrant Street, Brighton 3186.

Patient Signature: Date:

Name in full: (Please PRINT)