HEALTH SUMMARY

DURRANT MEDICAL CLINIC

Accredited General Practice

Title Mr Ms Mrs Mast Miss Dr (please circle)

Given Names **Surname**

Address:

Home: **Mobile:** **Gender:** Male / Female

Date of Birth: **Email:** **Occupation:** (incl. home duties/ student/ child)

Country of birth:

Aboriginal **Torres Strait Islander** **Neither** (please circle if applicable)

Emergency Contact:

Name:

Number:

Relationship to patient:

Medicare No.

_ _ _ _ _ _ _ _ _ _ Ref. _____ Expiry __ __/__ __ __ __

DVA No

_ _ _ _ _ _ _ _ **WHITE / GOLD** (please circle) 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:

Allergies (if any**):**

Do you drink alcohol now? YES / NO (please circle)
If so, how many days a week do you drink? 1–2 days 3-4 days 5-6 days Every day Less than Monthly
How many drinks per day
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) :

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Heart disease
- ☐ Stroke
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Eye condition
- ☐ Coeliac disease
- ☐ Blood clots
- ☐ Hepatitis
- ☐ Peptic ulcer
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Dermatitis/Eczema
- ☐ Psoriasis
- ☐ Dementia
- ☐ Migraines
- ☐ Seizures or fits
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Anaemia
- ☐ Abnormal pap smear
- ☐ Cancer of any type
- ☐ Diabetes

Any other conditions:

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

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?

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

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.

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

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

Signature: _____ Date:_____