DURRANT MEDICAL CLINIC

PATIENT HEALTH SUMMARY

Accredited General Practice

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: **Contact Number:**

Relationship:

Medicare No.
_ _ _ _ _ _ _ _ _ _ Ref. _____ Expiry __ __/__ __ __ __

DVA No
_ _ _ _ _ _ _ _ **WHITE / GOLD** (please circle) Expiry __ __/__ __ __ __

Health / Pensioners Card (please circle)
__ __ __ __ __ __ __ __ __ __ __ __ Expiry __ __/__ __ __ __

Proof of Photo ID: ☐ **Licence** ☐ **Student ID** ☐ **Other** **Sighted:**

Private Health Insurance (company, type of cover, extras):

BASIC **INTERMEDIATE** **TOP** (please circle)

Social/Family Structure

Who lives at home with you?

Are there any existing court orders on children 17 years and under? YES / NO (please circle)

Marital status:

No. of children:

No. of brothers or sisters you have:

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Previous General Practitioner:

Address:

Last seen on:

Phone:

(If you wish to transfer your records to our clinic, please complete 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 (1 per week) / 2-3 times a week / 4 or more times a week

How many standard alcoholic drinks do you have when drinking? 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 you do not drink alcohol, have you ever been a drinker? (if so year ceased):

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 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.* We do so via sms and phone calls.

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:_____

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Patient File 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

The patient has signed an authority requesting you to release this information.
Yours faithfully,
Durrant Medical Clinic
29 Durrant Street Brighton Vic 3186 www.durrantmc.com.au

----------**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) .....