305 Pier Street Perth WA 6000
P: (08) 6222 6622
F: (08) 6222 6611
E: admin@psmedical.com.au
W: www.psmedical.com.au
ABN: 30 167 195 262

PIER STREET MEDICAL

We need this information to provide the best quality care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. This form complies with the RACGP Standards for general practices.

PATIENT DETAILS

Title: _____ Surname: _____ Given Names: _____

Date of birth ___/___/___ Sex M ☐ F ☐ Country of birth_____

Home address: _____

Postal address: As above ☐ Other_____

Phone *(home)* _____ *(work)* _____ *(mobile)* _____

Email Address _____

Medicare No. _____ Ref No._____ Expiry date _____

Pension, Health Care Card or Veterans Affairs Number:
(if applicable) _____ Expiry Date_____ Private Health Fund ☐ Yes ☐ No

Occupation: _____ Employer: _____

First Language English ☐ Other_____

Do you consider yourself to be of Aboriginal or Torres Strait Islander origin? Yes ☐ No ☐
(Responding to this question is optional and is to assist with health initiatives)

How did you hear about our practice? Family/friend ☐ Signage ☐ Internet search ☐ Website ☐ Other ☐

Emergency Contact

Name_____ Relationship to you _____

Address As above ☐ Other_____

Phone (home_____ (work) _____ (mobile) _____

Next of Kin (if different to above)

Name_____ Relationship to you _____

Address As above ☐ Other_____

Phone (home_____ (work) _____ (mobile) _____

MEDICAL HISTORY

Height (cm) _____ Weight (kg) _____

IMMUNISATIONS

Childhood up to date ☐ Yes ☐ No ☐ Unsure

Adult ☐ Hep B ☐ 18/30yo MMR ☐ Tetanus ☐ Adult Flu & Pneumococcal

Please turn over…

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ALLERGIES, INTOLERANCES & SENSITIVITIES _____
_____

HISTORY OF MEDICAL PROBLEMS (including year of onset or diagnosis)
_____
_____
_____

HISTORY OF OPERATIONS AND SURGERIES (including year)
_____
_____

RELEVANT FAMILY MEDICAL HISTORY
_____
_____

CURRENT MEDICATIONS & DOSAGE (including over the counter medications) _____
_____
_____

Smoking status? ☐ Never ☐ Ex ☐ Current Number of cigarettes per day_____

Alcohol – how many alcoholic drinks do you have each week_____
(one standard drink = 425ml light beer/285ml full strength beer/100ml wine/30ml spirits/60ml port or sherry)

Physical Activity ☐ Nil ☐ Daily ☐ Weekly

Privacy Patient Information

To provide a high standard of medical care our practice undertakes research, professional development, and quality assurance/improvement activities. Any person accessing personal health information for this purpose has signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice ☐ Yes ☐ No

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, pap smears and other health reviews.

I consent to being contacted with reminders / Newsletters
Please note that Newsletters are sent out monthly ☐ Yes ☐ No

At times some of your medical information may need to be shared with other health care providers. Our practice uses encrypted email as a form of communication with other health professionals, for example, specialists.

I consent to my medical information being transmitted via email ☐ Yes ☐ No

Signature of patient or guardian _____ Date___/___/___

Please advise us if your contact information or Medicare details change.

Transfer of Health Information
You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.