north mitcham clinic


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|---|---|
| Dr. Andrew McDonald | 025653DY |
| Dr. Karen Louey | 047249BW |
| Dr. Chris Main | 034118AY |
| Dr. Patrick Crowe | 0362726W |
| Dr. Wendy Whitney | 041889BF |
| Dr. Janette Elderton | 043972EL |
| Dr. Joel Ten | 2979706J |
| Dr. Reyhan Panah | 427063DJ |
| Dr. Ishani Saraswat | 4465565T |
| Dr. Shikha Chhabra | 479217BL |
| Dr. Stephen Webster | 434598MY |
| Dr. Sajanie De Silva | 462044HH |
| Dr. Atchuthan Vigneswaran | 409504MT |


Please take a few minutes to complete this health questionnaire. The information we request assists us in providing you with the highest level of health care and is collected solely for our use in assisting you. Should you find the questions too personal or intrusive, please leave them unanswered and discuss this with your doctor. Thank you for helping us to help you!

Name _____ DOB _____

Country of birth: ◯ Australia ◯ Other _____ Language spoken at home _____

Do you identify as an: ◯ Aboriginal or Torres ◯ Strait Islander

Are you allergic to anything? Reaction:

_____ _____

_____ _____

_____ _____

Marital Status: _____ Occupation: _____ Next of Kin: _____

**Family History of:** ◯ Hypertension ◯ Heart Disease ◯ Colon cancer ◯ Breast cancer

◯ Stroke ◯ Depression ◯ Prostate Cancer ◯ Diabetes

Mother: ◯ Alive ◯ Deceased Death from: _____ Conditions: _____

Father: ◯ Alive ◯ Deceased Death from: _____ Conditions: _____

Brothers and sisters health: _____

Children – number and health: _____

_____

**Recreational/Exercise Activities:** _____

**Accommodation:** _____ Lives with: ◯ Alone Other: _____

Are you a carer for another or cared for yourself?: _____

**Alcohol:** ◯ Yes ◯ No Days per week you drink: _____ Drinks per day: _____

◯ **Never Smoked**

◯ **Smoker** Year started: _____ Cigarettes per day: _____

◯ **Ex Smoker** Year Started: _____ Year Stopped: _____ Cigarettes per day: _____


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Past Medical History? Operations, Chronic Conditions and Illnesses (include approx. dates)

Are you taking any medications? If so, please list them all, including those bought over the counter, vitamins, naturopathic or homeopathic medications and occasional medications.

When was your last tetanus shot?

Have you had any other **immunisations**? If so, what and when including last Flu Shot/Pneumonia?

**FEMALE patients** When was your last Pap smear?

Was the result normal? ◯ Yes ◯ No

Have you ever had an abnormal result? ◯ Yes ◯ No

Have you ever had a mammogram? ◯ Yes ◯ No When and what was the result?

Do you have children? ◯ Yes ◯ No

If so, when and how were they born (eg. by caesarean or natural delivery)

**MALE patients** Have you ever had a prostate check? ◯ Yes ◯ No

Is there any history of prostate disease in your family?

**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.

Do you wish to have any relevant health reminders sent to you? ◯ Yes ◯ No

Are there any other issues you wish to raise with us?

**Patient Consent**

I give consent for my Patient Health Information to be provided to Health Organisations such as The Pap Smear Registry and Immunisation Registry. This clinic also uses SMS and Email communication for reminders and clinical updates. If you do not wish to consent – please discuss this with your doctor.

Patient Signature