# LAKES BOULEVARD MEDICAL

HEALTH GROUP

547 The Lakes Boulevard, South Morang VIC 3752 | T: (03) 9436 0966 | F: (03) 9436 5900 | www.lakesboulevardmedical.com

**Once completed, please hand this registration form to reception**

**PATIENT INFORMATION**

| Title: | Name: | Surname: | D.O.B: |
|---|---|---|---|

| Phone;<br>H:<br>M:<br>W: | Address:<br><br>Postcode: | Occupation: |
|---|---|---|
| Are you Aboriginal or Torres straitislander? ◯ Yes ◯ No<br>Are you of Aboriginal or Torres strait islander origin? ◯ Yes ◯ No | | Country of birth: |

Email:

**If you have one of the cards below, please write the card numbers and expiry**

◯ Centrelink health care card:
◯ Centrelink pension card:
◯ Centrelink Seniors health card:
◯ Dept. of Veteran Affairs (DVA)Gold Card:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Defacto

I give permission for **Lakes Boulevard Medical, South Morang** to contact me via:

SMS ◯ YES ◯ NO
EMAIL ◯ YES ◯ NO

**IN CASE OF EMERGENCY**

| Name of local friend or relative: | Relationship: | Contact details: | Work phone no: |
|---|---|---|---|

I understand that Lakes Boulevard Medical complies with the privacy and data protection act 2014and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Lakes Boulevard Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent for Lakes Boulevard Medical to use and disclose my personal information (except when legal obligations must be met).

Patient/Guardian signature: Date:

**Please tell us how you have heard / known about us:** **Friend/ Family** ◯ **Flyer** ◯ **Newspaper** ◯ **Driving past** ◯ **Internet** ◯

**CONFIDENTIAL MEDICAL HISTORY QUESTIONAIRE**

Seen By **doctor** _____
Scanned □

**Once completed please hand this to your doctor**

Patient name: _____ Date of Birth: _____

**What medical concerns do you wish to discuss with your doctor today?**

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Past Medical History Have you suffered from any of the following – currently or previously, **what year**?

| | | | | |
|---|---|---|---|---|
| □ Heart Problems | □ Stroke | □High blood pressure | □ Blood clots | □ Glaucoma |
| □ Epilepsy | □ Anxiety/Depression | □ Asthma | □ Bronchitis | □ Diabetes |
| □ Back Pain | □ Eye Problems | □ Thyroid Problems | □ Hep C | □ Hep B |
| □ Liver Disease | □ Kidney disease | □ Osteoporosis | □ Fractures | □High Cholesterol |
| □ HIV | □ Any other? _____ | | | |

**Preventative Health: Please tick the boxes where appropriate**

| **ALL** | **FEMALES** | **MALES** | **Any Illnesses, operations or hospital admission?** |
|---|---|---|---|
| | | | |
| Bowel Screening □ Date: | Pap smear □ Date: | Prostate check □ Date: | |
| Skin Check □ Date: | Mammogram □ Date: | Testis check □ Date: | |
| Unintended weight change □ _____ since____ | | Health check □ Date: | |
| | Immunisations: | Immunisations: | |

**Medications and Social History:**

Please include ALL tablets, inhalers, patches, gels or injections – as well as any other ''natural'' remedies or supplements

| **MEDICATION** | **DOSE** | **FREQUENCY** | **SMOKER □ _____per day STARTED_____**<br>**NON SMOKER □ EX-SMOKER □ QUIT IN _____** |
|---|---|---|---|
| | | | |
| | | | **ALCOHOL _____ days per week _____ drinks per day** |
| | | | **NON-DRINKER □** |
| | | | **RECREATIONAL DRUGS □ Specify _____** |

| **FAMILY HISTORY** | **MOTHER** Alive ( Yes / No ) | **FATHER** Alive ( Yes / No ) | **SIBLINGS** |
|---|---|---|---|
| **Heart Attack** | □ | □ | □ |
| **Bowel Cancer** | □ | □ | □ |
| **Breast Cancer** | □ | □ | □ |
| **High blood pressure** | □ | □ | □ |
| **High Cholesterol** | □ | □ | □ |
| **Stroke** | □ | □ | □ |
| **Arthritis - Osteoarthritis/Rheumatoid?** | | □ | □ |
| **Diabetes** | □ | □ | □ |
| **Thyroid Disease** | □ | □ | □ |
| **Haemochromatosis** | | □ | □ |
| **Osteoporosis** | □ | □ | □ |
| **Other:** | □ | □ | □ |

**ALLERGIES**

_____
_____
_____
_____
_____

The Information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge.

Patient / Guardian Signature_____

Name: _____Surname:_____Date_____