Integrated Specialist Healthcare

Pre-Consultation Health Questionnaire

Personal Details

Title ☐ **Mr** ☐ **Ms** ☐**Other** **Name**			Date of Birth
Street Address			
Suburb		Postcode	
Contact Home	Work		Mobile
Email			
Medicare no	Exp	Ref	DVA No.
Private Health Fund		Fund Number	
Occupation	Weight		Height
☐ Married ☐ Single			
Next of kin	Relationship		Contact
Referring Dr		GP	

Social History

Do you smoke? ☐ Y ☐ N	Daily intake:	Years smoking:
Do you drink alcohol? ☐ Y ☐ N	Daily intake:	

Surgical History

Have you had any blood transfusions? ☐ Y ☐ N	In which year:
Do you have any allergies? ☐Y ☐ N	List:
Have you had any previous surgeries? ☐ Y ☐ N (if yes please list in boxes below)	

Medical History

Please tick if you have any of the following:			
☐ Cancer/Leukemia	☐ Rheumatic Fever	☐ Depression	☐ Healing problems
☐ Diabetes	☐ Blood clots	☐ Hepatitis	☐ Keloid Scars
☐ Blood Pressure	☐ Spinal/neck problems	☐ Skin disorders	☐ Wound infections
☐ Heart condition	☐ Eye conditions	☐ Cold Sores	
Do you have any other significant health problems? ☐ Y ☐ N			

Collection of Personal Information, Privacy Act 1988 (Cth) and HRIP Act 2002 (NSW)

Integrated Specialist Health Care collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assist, diagnose and treat illnesses and be proactive in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of teaching. Please let us know if you do not want your records accessed for this purpose, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to opt-out of any involvement

I have read the information above and understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am also aware that this practice has a privacy policy that contains information about accessing and seeking correction of personal information, privacy complaints handling process, and whether the practice is likely to disclose personal information to overseas recipients.

I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate. I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Name: _____ Date: _____

Signed: _____