CAPALABA GENERAL PRACTICE

5 Larbonya Crescent, Capalaba Q 4157
Phone: 3245 3011 Fax: 3245 3022 Email: reception@capalabagp.com.au

Patient Information Sheet & Privacy Statement

Title: _____ Surname: _____ First Name: _____

Middle Name: _____ Preferred Name: _____ D.O.B: _____

If Child – full name of Parent: _____ D.O.B: _____

Do you identify as: (Please √ Relevant Box)

☐ Aboriginal ☐ Torres Strait Islander ☐ Australian (Non-Indigenous) ☐ Other Nationality: _____

Address:_____ Suburb: _____ Post Code: _____

Home Ph: _____Mobile: _____ Work Ph: _____

Email: _____ Do you consent to SMS Reminders?: ☐ Yes ☐ No

Medicare Card.: _____ Line Number: _____ Expiry Date: _____

Pension/Health Care Card: _____ Expiry Date: _____

DVA (Gold/White) Card: _____ Expiry Date: _____

Private Health Fund: _____ Membership Number: _____

Next of Kin:
Name**:** _____ Phone _____ Relationship _____

Emergency Contact: Same as next of kin ☐ / or
Name**:** _____ Phone _____ Relationship _____

Do you have any cultural or religious beliefs that might be relevant to your medical care : Yes ☐ No ☐

Do you wish to enrol other Dependants living at home who may wish to attend this practice:

NAME	D.O.B.	RELATIONSHIP	MEDICARE NUMBER or (AS ABOVE)	Medicare Line #

I wish to consult at Capalaba General Practice. I understand that I will be required to pay for all services for which a charge is applicable at the time they are provided.

Signature of patient:_____

Please Turn Page over

Consent to Privacy Policy and Collection Statement

Capalaba General Practice has a Privacy Policy that outlines the way we collect and use your information and how you can access that information. This privacy consent covers collection and use of your information to provide comprehensive, co-ordinated and continuing whole person medical care. As outlined in the Privacy Policy, your information may be disclosed to other health care professionals such as Medical Practitioners, Pathology/Radiology to provide this level of care.

Separate, specific consent is required if your information is used for research, statistical or quality assurance purposed, or if the practice changes ownership and the services offered are significantly different from those provided by Capalaba General Practice.

If you have any questions in relation to this consent form of our Privacy Policy, please ask our staff or the Doctors.

By signing this consent form you acknowledge that you have read the privacy statement and agree to your information being collected and used as described in the Privacy Policy.

Signature of patient/person responsible*:_____

*A 'person responsible' means a person defined as a 'person responsible' under the Privacy Act 1988 including the patient's partner, family member, care, guardian, close friend, and a person exercising power under an enduring power of attorney. A fully copy of our privacy policy is available at Reception or on our website.

Consent Form for Clinical Photography at Capalaba General Practice

Photographs are often routinely taken by the doctors at this practice who treat skin cancer, by the practice melanographer or by other staff under supervision, to form a part of your medical record. This may include photos of moles, other skin or medical conditions or surgical procedures. Photographs from medical records may be very helpful for other medical purposes, so we seek your consent to possibly use the photographs in your medical record for the following purposes.

- Getting an opinion from other expert doctors (at no cost to you).
- Educating other health professionals and medical students (Professor Rosendahl is a Professor at the University of Queensland), other patients and in presentations to community groups. This includes use on medical web-sites, posters and brochures.
- Medical research and publication. Professor Rosendahl is involved in research to improve the diagnosis and treatment of skin cancers and publishes the results of this research in medical journals, text books and educational posters. This research may include sending images to doctors who are researchers in international locations, most commonly at the Medical University of Vienna, Austria.

Doctors undertake that if any photographs from your medical record are used, they will be presented in such a way that you are not identified. If it is reasonably foreseeable that you may be identified from a photograph, we will not publish it without your further specific consent.

You can withdraw your consent at any time but you should be aware that photographs cannot be withdrawn once they have been published.

I have read the information on this page and ***I consent to photographs from my medical record*** (including any already taken) ***being used for the purposes listed above including for teaching and medical research.***

Signature of patient:_____

Print Full Name:_____***Date*** _____

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PATIENT HISTORY

Please complete front page and take into your doctor for your appointment

SURNAME:_____ **FIRST NAME:**_____ **D.O.B.:**_____

MEDICATION ALLERGIES:_____

OTHER ALLERGIES: _____

CURRENT MEDICATION: _____

_____

_____

CURRENT & PREVIOUS MEDICAL HISTORY:
(EG. High blood pressure, Heart/Cardiac , Diabetes, Asthma, Cancer, Mental Illness, Alzheimer's etc.)

_____

_____

_____

SERIOUS ILLNESS:_____

_____

_____

OPERATIONS: (eg. Tonsils, Appendix, Gall Bladder, Hysterectomies, Prostate)

_____

_____

FAMILY HISTORY: ie. Parent, Siblings, Grandparents etc. (eg. High blood pressure, Heart Disease, Diabetes, Asthma, Cancer, Mental Illness, Alzheimer's etc.)

_____

_____

SMOKER: ☐ **YES** ☐ **PAST SMOKER** ☐ **NEVER SMOKED**

ALCOHOL: ☐ **NEVER** ☐ **MONTHLY OR LESS** ☐ **2-4 TIMES/MONTH**
☐ **2-3 TIMES/WEEK** ☐ **4 OR MORE TIMES/WEEK**

NUMBER OF DRINKS: ☐ **1-2** ☐ **3-4** ☐ **5-6** ☐ **7-9** ☐ **10 OR MORE**

LAST CERVICAL SCREENING: (Previously Pap Smear)
YEAR:_____ ☐ **NORMAL** ☐ **ABNORMAL** ☐ **NEVER**

LAST MAMOGRAM: YEAR:_____ ☐ **NORMAL** ☐ **ABNORMAL** ☐ **NEVER**

COUNTRY OF BIRTH: _____