McKinley Medical Centre

433 Police Road
Mulgrave, VIC 3170
Ph (03) 9795 4011
e: info@mckinleymc.com.au
mckinleymc.com.au

PLEASE COMPLETE ALL 5 PAGES

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Could you please assist us by completing the following?

Family Name:					
Given Name					
Name Title					
Street Address:					
Suburb:		Postcode:			
Date of Birth:					
Ethnicity:					
Are you of Aboriginal or Torres Strait Islander Origin:	☐ Yes ☐ No				
Home Phone:					
Mobile Phone :					
Work Phone:					
Email :					
Consent to contact via *(please tick)*	☐ Mail ☐ Phone - Home ☐ Email ☐ Phone – Work ☐ SMS ☐ Phone – Mobile				
Medicare Number		Ref on card		Expiry Date	
DVA Gold / White (Please circle)				Expiry Date	
Pension Number				Expiry Date	
Health Care Card Number				Expiry Date	
Private Health					
Next of Kin Name Relationship Phone number Address					

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Emergency Contact (Name and Phone number of the person we can contact if needed)	

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

If we need to contact you what is your preferred method of contact:

☐ Phone ☐ Mail ☐ Email

Do you wish to receive SMS reminders for appointment times?

☐ Yes ☐ No

Australia is a genuinely multicultural society. To tailor appropriate care for people from different nationalities and backgrounds:–
Do you identify as from a culturally diverse and/or non- English speaking background?

If Yes, are you of or from?

☐ Aboriginal or Torres Strait Islander origin
☐ China
☐ Greece
☐ India
☐ Iraq
☐ Italy
☐ Korea
☐ Malaysia
☐ New Zealand
☐ Philippines
☐ Sri Lanka
☐ Sudan
☐ Thailand
☐ United Kingdom
☐ Vietnam
☐ Other cultural or ethnic background (please indicate) _____
☐ No

Health History - Do you have or had a history of?

☐ Operations _____

☐ Asthma_____

☐ Diabetes_____

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☐ Hypertension_____

☐ Chronic illness_____

☐ Other _____

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes (If yes please list below) ☐ No

Immunisations - Have you had the following immunisations?

Tetanus booster	date_____	☐ Don't Know	☐ Haven't had one
Hepatitis B	date_____	☐ Don't Know	☐ Haven't had one
Hepatitis A	date_____	☐ Don't Know	☐ Haven't had one
Influenza	date_____	☐ Don't Know	☐ Haven't had one
Pneumococcal	date_____	☐ Don't Know	☐ Haven't had one
Polio	date_____	☐ Don't Know	☐ Haven't had one

Children's Immunisations - If completing this form for a child are their immunisations up to date?

☐ Yes ☐ No ☐ Unsure?

Current Medications (including over the counter medications, vitamins and minerals)

_____

_____

_____

_____

_____

Family History - Have any members of your family had?

☐ Diabetes_____

☐ Asthma_____

☐ Heart Disease_____

☐ Mental Illness_____

☐ Cancer _____

Social History

☐ Tobacco: _____ day / week or Ceased Smoking - date _____
☐ Alcohol: _____ day / week / month (circle the one applicable)
☐ Drug use: _____ (type and frequency)

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Height: _____ Cms Weight: _____ Kgs

Blood Pressure: When was the last time your blood pressure was taken? _____

Please go to page 4

Sun Protection: How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

For those 65 years and older: When was the last time you were immunised?

Influenza	Date_____	☐ not sure	☐ never
Pneumococcal pneumonia	Date_____	☐ not sure	☐ never

Females: When did you last have?

Pap smear	Date_____	☐ not sure	☐ never
Breast check	Date_____	☐ not sure	☐ never
Skin check	Date_____	☐ not sure	☐ never

Males: When did you last have?

An overall check-up	Date _____	☐ not sure	☐ never
Skin check	Date_____	☐ not sure	☐ never

Do you have any health concerns you would like to receive information on?

_____

_____

_____

_____

Please go to Consent Form

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CONSENT FORM

We require your consent to collect personal information about you. Please read this consent form carefully and sign where indicated below.

This medical practice 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 assess, diagnose, treat and be pro-active in your health care needs. This means we will use the information you provide us 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 healthcare including treating doctors and specialists outside this medical practice. This may occur through the referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we note in your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management, all information in these instances is un-identified. These activities are ongoing within the practice. I have read the information above and understand the reasons why any information must be collected. I am also aware that this practice has a privacy policy on handling information.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of healthcare and treatment given to me. I understand that if any information is to be used for any other purpose other than set out above, my further consent will be obtained.

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

☐ *(Please tick if agree)* I am happy to receive Appointment and/or Recall SMS text reminder messages.

Signed.....

Name.....Date.....

Signed as Guardian of child.....

Name.....