Essendon Day
Procedure Centre

CONFIDENTIAL PATIENT HISTORY

In accordance with the Health Records Act 2001 and the Privacy Act 1988

Please read carefully. If you need an interpreter, please notify our staff and one will be arranged for you.

Declaration

I provide consent for the collection of necessary personal health information and agree to the transfer of relevant health information to other healthcare providers who may be participating in my treatment when requested. It is my understanding that the EDPC staff will make reasonable steps to ensure that I am generally aware of the circumstances under which this information is released. I have read and understand the

1. Privacy Statement
2. Private Patients Hospital Charter (PPHC) or Australian Charter of Healthcare Rights (ACHCR)- *available in multiple languages. Please ask our reception staff*
3. Complaints management process.
4. Child Safety Statement

I understand that fees are the responsibility of the patient, parent or guardian. Medicare does not cover admission to a private or public hospital.

I will inform my doctor of any advanced care directives or treatment limiting orders at my first consultation

To the best of my ability the attached medical history is true and correct.

Name:_____

Signature:_____

Date:_____

Please turn over and complete details

PATIENT HISTORY *(Please circle correct response and complete where needed)*

Dr/Mr/Mrs/Ms/Miss/Mst: **SURNAME**: _____ **FIRST NAME**:_____

DATE OF BIRTH: (D)_____(M)_____(Y)_____ **MALE/FEMALE**

MARITAL STATUS: Married/Defacto/Widow/Single **COUNTRY OF BIRTH**: _____

Are you of Aboriginal or Torres Strait Island Descent? YES/NO OCCUPATION:_____

CONTACT DETAILS: *(HOME)*_____*(WORK)*_____*(MOBILE)*_____

ADDRESS: _____

SUBURB: _____*POST CODE:* _____

POSTAL ADDRESS if different:_____

NEXT OF KIN: _____*(RELATIONSHIP)*:_____PHONE:_____

Emailed Receipt? YES/NO EMAIL: _____

Do you have Hospital Insurance? YES/NO **Do you have Dental Extras? YES/NO**

NAME OF HEALTH FUND:_____ **MEMBERSHIP NO**:_____

MEDICARE NO: _____ **REF NO (number next to your name):**_____**EXP:**_____

Veteran Affairs NO:_____ **TAC/WORK COVER CLAIM NO**: _____

NAME OF DENTIST:_____**NAME OF LOCAL DOCTOR**:_____

PERSON RESPONSIBLE for ACCOUNT *(if different from above)*: Dr/Mr/Mrs/Ms/Miss_____

Email:_____Address:_____PH:_____

MEDICAL HISTORY QUESTIONNAIRE

Your medical history responses are confidential & remain within this practice. You have access to this form at any time for update or correction. We collect this information to ensure safe and appropriate treatment is delivered to you whilst in our care.

1. List all medications you are taking (including the Contraceptive, Aspirin, WARFARIN, prescription, over the counter and complementary medicines_____

   _____

2. Have you ever been in hospital? YES/NO If yes when and why

   _____

   _____

3. Have you ever had a serious illness or disease? YES/NO If yes _____
4. Do you have a bleeding disorder/bleeding problems? YES/NO If yes_____
5. a) Are you allergic to Penicillin? YES/NO b) Are you allergic to Latex? YES/NO
6. Are you allergic to any other substances? Yes /No. Please list allergy and reaction

   _____

7. Have you ever had a general anaesthetic? YES/NO Did you experience any complications? YES/NO Please explain.

   _____

8. Have you had an overnight stay in an overseas hospital or a residential aged care facility in the past 12 months?_____
9. Please list and inform your surgeon of any current infection or illness i.e. gastro, flu: _____
10. Have you had 2 or more accidental falls in the past 12 months? YES/NO

FEMALES ONLY: 11. a) Are you pregnant? YES/NO if yes, how many months? _____ b) Are you breastfeeding? YES/NO