

PAST MEDICAL HISTORY:	YES	NO	PLEASE SPECIFY
Neurological (Eg. Brain)			
Respiratory (E.g. Asthma)			
Heart (Eg. Heart attack)			
Endocrine (E.g. Diabetes)			
Urinary (E.g. UTI)			
Gynaecology (E.g. Period pain)			
Gastrology (E.g. Reflux, IBS)			
Musculoskeletal (E.g. Osteoarthritis)			
Vascular (E.g. DVT)			
Others			

FAMILY MEDICAL HISTORY:	YES	NO	WHO
Heart related, please specify			
Stroke			
Diabetes, please specify			
Breathing related			
Bleeding related			
Cancer, please specify			
Mental health related, please specify			
Others, please specify			

OUR PRIVACY AND MEDICAL INFORMATION

Complying with The Privacy Act, your consent is required for information collected. 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 access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management, in which your consultation may include the presence of a medical student or GP registrar. All information is de-identified. If you wish to opt out of any research undertaken by the clinic please inform your doctor. We wish to assure you that at all times your health information is treated with utmost confidentiality. **In accordance to medical legislations, doctors and staff in this practice will not discuss test results over the phone.**

I have read and understood the above information regarding my medical information.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** / /

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FOR STAFF USE ONLY

DRIVERS LICENCE/PHOTO ID NUMBER: _____ **SIGHTED BY:** _____ **DATE:** / /