Ilam Medical Centre
HEALTH MATTERS

# PATIENT CLINICAL INFORMATION UPDATE

**Family Name:**
**Given Names:**
**Street:**
**Suburb:**
**City:**
**Work Phone:**
**Cell Phone:**
**Contact in case of emergency:** Name:
Address:
Cell phone number:

**NHI:**
**DOB:**
**Gender:**
**Sex at Birth:**
**GMS:**
**High Use:**
**Home Phone:**

Other phone number:

**Please answer the following questions as well as you are able from memory. We will use your medical files to check dates and obtain further information.**

**Are you taking any Medications? (please circle)** Yes / No
Please list current medication with dosage/attach a list of medications:

**Do you have any Allergies to medication? (please circle)** Yes / No
If yes, please list allergies AND reaction:

**What is your Current Occupation?**

**What is your Living Situation?**

**Level of Exercise (please circle):** Nil 0-1 hr/wk 1-2 2-3 > 3

**Smoking status (please circle):** Non-smoker Ex-smoker Current smoker: no. per day ____

**Vaping status (please circle):** Non-vaper Ex-vaper Current vaper: pods per week _____

**Alcohol intake (please circle):** nil 0-5 drinks/wk 5-10 10-20 20-30 > 30

**Recreational Drug Use (please circle):** nil use occasional use frequent use

**Personal Medical History (please circle):**

Stroke Heart attack High blood pressure Diabetes Asthma Emphysema/Bronchitis

Bowel cancer Breast cancer Cancer (other: _____) Arthritis Rheumatic fever

Hepatitis/liver problem Kidney/bladder problem

Abdominal surgery Orthopaedic surgery (joints and bones) Gynaecological surgery or disorder

Other significant medical problems:

**Family medical history (please circle):**

**Father:** Stroke, heart attack, high cholesterol, blood pressure, diabetes, cancer of prostate, cancer of bowel, mental health

**Mother:** Stroke, heart attack, high cholesterol, blood pressure, diabetes, cancer of breast, cancer of bowel, mental health

**Siblings:** Stroke, heart attack, high cholesterol, blood pressure, diabetes, cancer of prostate / bowel / breast, mental health

Other significant family health issues:

**Do you have a disability? (please circle)** Yes / No
If yes, please specify:
E.g. Hard of hearing, visual impairment, mobility difficulty

**Do you have any cultural or religious beliefs which may be important to your care?**
**(eg, Jehovah's Witness)** Yes / No
please specify:

**Female patients only:**
When did you last have a cervical smear taken? ..... N/A

When did you last have a mammogram? ..... N/A

**Male patients only:**
When did you have your last digital rectal exam? ..... N/A

**Patients under 18years of age:**
Please provide written evidence of your immunisation history (particularly if vaccinations were completed overseas) so that we can ensure our records are up to date.

**Disclosing of Information**:
Do you have an EPOA in place? Yes / No
If yes, please advise of name, contact details, and provide evidence of activation.
Name:
Contact:

Would you be interested in developing an advanced care plan? Yes / No

Do you consent to anyone else having access to your medical records? Yes / No
If yes, please specify who:

**Thank you for your time!**