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Clifton Hill VIC 3068  
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P: 9489 7955 // F: 9489 7944



**Personal Details**

***A complete medical history is important for us to provide you with optimum health care. Please discuss anything you are unsure of with your doctor.***

Title: Surname: First Name:

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status (circle): Single / Married / Engaged / Divorced / De Facto / have a partner /Widowed

Address: Suburb:

Phone Home: Work: Mobile:

Email:

*Do you consent to receiving information about Wellness Medicine via email? (circle) Yes / No*

Medicare Number: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Expiry \_\_ \_\_/ \_\_ \_\_ PRN No. \_\_\_\_

Pension Number: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Expiry \_\_ \_\_/ \_\_ \_\_ Aboriginal/Torres Strait Islander: YES / NO

Emergency contact: Contact Number: Relationship:

Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year:

How did you hear about this centre? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live (circle) alone/ house share/ with family?

Smoker: Yes / No / Ex-smoker per day AlcoholYes / No / Social per week

Drugs Yes / No Is your diet: Poor / Fair / Good

(If vegetarian) do you eat dairy, eggs or fish? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? No / Yes How many days a week do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign here to indicate that you are providing true and correct information, and that you have read and accepted our **Patient Privacy Policy** and **Cancellation Fee Policy.**

**Signature patient/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Transfer of Health Information**:

You may have consistently consulted with a GP at another practice. The health information held by the GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask receptionist for information about how this can take place.

**Do you have any allergies to medicines or anything else?** NO / YES

To what? Reaction?

Current Medications (including over the counter medication)

|  |  |  |
| --- | --- | --- |
| **Name of medication** | **Strength** | **Times taken** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever had any major operations or been admitted to hospital/ seen a specialist?

|  |  |
| --- | --- |
| **Year** | **Reason** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Preventative Health**

Have you ever had?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Problems (circle)** | **Year began** | **Active now** | **Serious Infection (circle)** | **Year began** | **Active now** |
| Angina |  |  | Skin rashes, dermatitis, eczema, psoriasis |  |  |
| High Blood Pressure |  |  | Epilepsy/fits/blackouts/  strokes |  |  |
| High cholesterol |  |  | Migraine |  |  |
| Varicose veins, clots or blocked arteries |  |  | Asthma/Emphysema |  |  |
| Stomach ulcers |  |  | Hay fever/ sinus problems |  |  |
| Gall stones |  |  | Eye/ ear problems |  |  |
| Liver disease, Jaundice, Hepatitis |  |  | Back/neck problems |  |  |
| Pancreatitis |  |  | Serious trauma |  |  |
| Hernia/ bowel problems |  |  | Emotional disorder/ stress |  |  |
| Rectal bleeding |  |  | Kidney/ urine/ bladder problems |  |  |
| Diabetes |  |  | Prostate problems/ impotence |  |  |
| Thyroid problem |  |  | Abnormal pap smear |  |  |
| Gout |  |  | Sexually transmitted disease |  |  |
| Arthritis/ Joint problems |  |  | AIDS |  |  |
| Cancer – where? |  |  | Intravenous drug use |  |  |

When was your last check for the following?

|  |  |
| --- | --- |
| **Medical History** | **Year** |
| Cholesterol |  |
| Blood Pressure |  |
| Prostate Check |  |
| Pap Smear |  |
| Bowel Cancer |  |
| HIV Test |  |
| Hepatitis Test |  |

**Immunisation:**

Did you have all your normal childhood vaccinations? (Circle) YES / NO

Have you had a tetanus booster? (Circle) YES / NO when?

Have you had any additional vaccinations? E.g. for travel

If so what and when?

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunisation:** | **Year** | **Immunisation:** | **Year** |
| **Tetanus** |  | **Chicken Pox** |  |
| **Rubella** |  | **Influenza** |  |
| **Hepatitis A** |  | **Pneumonia** |  |
| **Hepatitis B** |  | **Measles** |  |
| **Meningococcal** |  | **Cholera** |  |
| **Typhoid** |  |  |  |

**Family History**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Has anyone related to you ever had:(circle)** | **TYPE** | **Relationship to you** | **Ever had 🗹** | **Age of onset** | **Died from 🗹** | **AGE** |
| **High blood pressure** |  |  |  |  |  |  |
| **High cholesterol** |  |  |  |  |  |  |
| **Heart attack/angina** |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |
| **Anaemia** |  |  |  |  |  |  |
| **Bleeding disorder** |  |  |  |  |  |  |
| **Asthma/ emphysema** |  |  |  |  |  |  |
| **Tuberculosis** |  |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |
| **Kidney disease** |  |  |  |  |  |  |
| **Cancer or tumour** |  |  |  |  |  |  |
| **Depression/anxiety** |  |  |  |  |  |  |
| **Mental Health disorder** |  |  |  |  |  |  |
| **Thyroid problems** |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |

**CDM NET**

**CDM net is a secure online portal where you are able to have access to your health record at any time including history, results and medication summaries. Would you like to have your health record transferred to CDM net? YES / NO**