Doctors at Teneriffe

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:

Title	**Mr**	**Mrs**	**Ms**	**Miss**	**Master**
Surname					
First Name/s				**Known as**	
Date of Birth					
Street Address					
Suburb and Post Code					
Home Phone					
Work Phone					
Mobile Phone				Consent to SMS : Y / N	
Email					
Medicare Number				**Expiry Date**	**Reference number (left of name)**
DVA Gold / White (Please circle)				**Expiry Date**	
Pension Number				**Expiry Date**	
Health Care Card Number				**Expiry Date**	
Private Health Cover					
Next of Kin (Name and Telephone number)	Relationship				
Emergency Contact	(Name and Telephone number of the person we can contact if needed, **not in the same household)** Relationship				
Employer Name					
Employer Address					
Employer telephone no.					
Occupation					
Country of Birth					

HOW DID YOU HEAR ABOUT
OUR SURGERY - Friend/Relative/ etc…….....

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

☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email

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

_____

_____

_____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds –Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes - Please elaborate……

☐ What is your preferred language (if not English)……

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SURNAME: _____FIRSTNAME: _____

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Your health history - do you have or have you had a history of? Date & year if possible

☐ Operations

_____

☐ Asthma

_____

☐ Diabetes

_____

☐ High Blood Pressure

_____

☐ Other illness

_____

Do you have any allergies? Are you sensitive to drugs or dressings?:

☐ Yes (If yes please list below & your reaction) ☐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

Current medications & dosage if known.
(including over the counter medications, vitamins and minerals):

1_____ 7_____
2_____ 8_____
3_____ 9_____
4_____ 10_____
5_____ 11_____
6_____ 12_____

Family history - have any members of your family had the following and if so who: eg. mother, father etc

☐ Diabetes

_____

☐ Asthma

_____

☐ Heart Disease

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☐ Mental illness

☐ Cancer

☐ Bowel Cancer

☐ Ovarian Cancer ☐ Breast Cancer

Social history

☐ Marital Status: Single/ Married/ Divorced/ Widowed/ Defacto (circle the one applicable)

☐ Sexuality – Heterosexual/ Homosexual/ Bisexual

☐ Occupation_____

☐ Tobacco: Y/N_____ day / week Start date_____ or Ceased Smoking - date _____
☐ Alcohol: Y/N number of drinks_____ per_____ day / week / month
☐ Drug use: Y/N _____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs

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

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	☐ Result_____
Mammogram	Date_____	☐ not sure	☐ never	☐ Result_____

Males: When did you last have?

An overall check up	Date _____	☐ not sure	☐ never
Prostate Check	Date_____	☐ not sure	☐ never

Doctors at Teneriffe

We require your consent to collect information about you. Please read this information 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 proactive in your health care needs. This means we will use the information you provide 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 health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice and locums for the purpose of patient care. Please let us know if you do not want your records accessed for this purpose and will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information and if I have not attended, my records will be destroyed by incineration after 7 years.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

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

Signed: …… (patient) Date: ……

Should you have any concerns regarding a breach of your privacy, please contact our Practice Manager or your Doctor. If you wish to take the matter further and feel that you need to discuss the matter outside the surgery, the Health Rights Commission may be contacted on 3234 0333.

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The Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)

1. Your age group

Under 35 years	0 points
35 – 44 years	2 points
45 – 54 years	4 points
55 – 64 years	6 points
65 years or over	8 points

2. Your gender

Female	0 points
Male	3 points

3. Your ethnicity/country of birth:

3a. Are you of Aboriginal, Torres Strait Islander, Pacific Islander or Maori descent?

No	0 points
Yes	2 points

3b. Where were you born?

Australia	0 points
Asia (including the Indian sub-continent), Middle East, North Africa, Southern Europe	2 points
Other	0 points

4. Have either of your parents, or any of your brothers or sisters been diagnosed with diabetes (type 1 or type 2)?

No	0 points
Yes	3 points

5. Have you ever been found to have high blood glucose (sugar) (for example, in a health examination, during an illness, during pregnancy)?

No	0 points
Yes	6 points

6. Are you currently taking medication for high blood pressure?

No	0 points
Yes	2 points

7. Do you currently smoke cigarettes or any other tobacco products on a daily basis?

No	0 points
Yes	2 points

8. How often do you eat vegetables or fruit?

Everyday	0 points
Not everyday	1 point

9. On average, would you say you do at least 2.5 hours of physical activity per week (for example, 30 minutes a day on 5 or more days a week)?

Yes	0 points
No	2 points

10. Your waist measurement taken below the ribs (usually at the level of the navel, and while standing)

Waist measurement (cm) ☐

For those of Asian or Aboriginal or Torres Strait Islander descent:

Men	Women	
Less than 90 cm	Less than 80 cm	0 points
90 – 100 cm	80 – 90 cm	4 points
More than 100 cm	More than 90 cm	7 points

For all others:

Men	Women	
Less than 102 cm	Less than 88 cm	0 points
102 – 110 cm	88 – 100 cm	4 points
More than 110 cm	More than 100 cm	7 points

Add up your points ☐

Your risk of developing type 2 diabetes within 5 years*:

☐ 5 or less: Low risk
Approximately one person in every 100 will develop diabetes.

☐ 6 – 11: Intermediate risk
For scores of 6–8, approximately one person in every 50 will develop diabetes. For scores of 9–11, approximately one person in every 30 will develop diabetes.

☐ 12 or more: High risk
For scores of 12–15, approximately one person in every 14 will develop diabetes. For scores of 16–19, approximately one person in every seven will develop diabetes. For scores of 20 and above, approximately one person in every three will develop diabetes.

*The overall score may overestimate the risk of diabetes in those aged less than 25 years.

If you scored 6–11 points in the AUSDRISK you may be at increased risk of type 2 diabetes. Discuss your score and your individual risk with your doctor. Improving your lifestyle may help reduce you risk of developing type 2 diabetes.

If you scored 12 points or more in the AUSDRISK you may have undiagnosed type 2 diabetes or be at high risk of developing the disease. See your doctor about having a fasting blood glucose test. Act now to prevent type 2 diabetes.

The Australian Type 2 Diabetes Risk Assessment Tool was originally developed by the International Diabetes Institute on behalf of the Australian, State and Territory Governments as part of the CDAC Diabetes reducing the risk of type 2 diabetes initiative.

Doctors at Teneriffe

LungCensus

Screening Questionnaire

Age: ☐☐ Years **Gender:** Male ☐ Female ☐ **Height:** ☐•☐☐ Metres

1. Have you ever been told you suffer from chronic bronchitis, emphysema or COPD?	Yes ☐	No ☐
2. Have you ever been told that you suffer from asthma?	Yes ☐	No ☐
3. Are you troubled by cough, phlegm, mucus or wheezing?	Yes ☐	No ☐
4. Do you get out of breath more easily than others of your age?	Yes ☐	No ☐
5. Are you a current smoker?	Yes ☐	No ☐
6. Have you ever smoked?	Yes ☐	No ☐
7. Do you feel that you have been significantly exposed to passive smoking?	Yes ☐	No ☐
8. Do you feel that you have been significantly exposed to pollution at work or in the air?	Yes ☐	No ☐
9. Has anyone in your family had emphysema or chronic bronchitis?	Yes ☐	No ☐
10. Are you troubled by repeated chest infections?	Yes ☐	No ☐

COPD-6 Breathing Test

FEV_1: ☐.☐☐ L	FEV_1: % predicted ☐☐	FEV_6: ☐.☐☐ L	Ratio FEV_1/FEV_6: 0.☐☐

If the ratio is less than 0.70 please repeat the test and record results below

FEV_1: ☐.☐☐ L	FEV_1: % predicted ☐☐	FEV_6: ☐.☐☐ L	Ratio FEV_1/FEV_6: 0.☐☐

If the ratio is less than 0.70 please repeat the test and record results below

FEV_1: ☐.☐☐ L	FEV_1: % predicted ☐☐	FEV_6: ☐.☐☐ L	Ratio FEV_1/FEV_6: 0.☐☐

Disclaimer: This questionnaire and your participation in the Lung Census is intended to make you think about your lung health. It does not replace advice and consultation from your usual healthcare provider. If you have any questions or concerns about the questionnaire, or any other aspect of your health, please discuss these with your healthcare provider.

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For further information regarding the Lung Census, please contact MediMark International. 34 Heversham Drive, SEAFORD, VIC 3198
Ph: 1300 952 100 • Fax: 1300 952 111 • Email: lungcensus@medimark.com.au • www.medimark.com.au