CARN-BRAE CLINIC

17 Errard Street North, Ballarat, VIC, 3350
Phone: (03) 5332 1501 **Fax:** (03) 5331 8860

Dear Patient,

We would like to take this opportunity to welcome you as a patient to our practice.

Please be advised that we are a private practice, therefore only Pension and Health Card Holders will be bulk billed. Private patients will be required to settle your account in full after the consultation. A list with standard fees is located in the waiting room.

There will be charges for non-attendance of consultations

Dr Ahmed Alwan, Dr Frank Marton, Dr Shirani Kodituwakkuarachchi
& Dr Dileepa Jayaweera.

Please sign below to indicate that you agree to our financial arrangements:

Patient Name: ______________________________________

Patient Signature: ______________________________________

Seeing Doctor: ☐ Dr Alwan ☐ Dr Marton ☐ Dr Shirani ☐ Dr Jayaweera

How did you find out about Carn-Brae Clinic?

☐ Radio Advertisement ☐ Website/Google Search ☐ Hospital/Health Professional

☐ Family/Friends ☐ Other - Please Specify: ……………………………………………

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Patient Details

Family Name: Mr / Mrs / Miss / Ms ______________________________

Given Names: ______________________________

Date of Birth: ___ / ___ / ______ Age: _______ Sex: Male / Female

Height: ______________ Weight: ______________

Cultural Background: ______________________________
(eg. Aboriginal, Torres Strait Islander)

Address

Street: ______________________________

Suburb: ______________________ Post Code: ______________

Home: ____________ Work: ____________ Mobile: ____________

Medicare and Concession Information

M/care #: __ __ __ __ - __ __ __ __ __ - __ Ref: __ Expiry: __ __ (m)/ __ __ (y)

Pension #: __ __ __ - __ __ __ - __ __ __ __ Expiry: __ __ (d)/ __ __ (m)/ __ __ (y)

H.C.C. #: __ __ __ - __ __ __ - __ __ __ __ Expiry: __ __ (d)/ __ __ (m)/ __ __ (y)

Emergency Contact / Next of Kin

Name of Contact: ______________________________

Relationship: ______________________ Phone: ______________

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CARDIOVASCULAR	**YES**	**NO**	**Specify…**	**Family History** ☐
Angina / Chest Pain / AMI	☐	☐	____________	
Hypertension / Hypotension	☐	☐	____________	
High Cholesterol	☐	☐	____________	
Thromboembolism	☐	☐	____________	
Rheumatic Fever	☐	☐	____________	
Cardiac Failure	☐	☐	____________	
Arrhythmia	☐	☐	____________	
Pacemaker / ACID Insitu / Stents	☐	☐	____________	
Other Conditions	☐	☐	____________	

RESPIRATORY	**YES**	**NO**	**Specify…**	**Family History** ☐
Tuberculosis	☐	☐	____________	
Asthma	☐	☐	____________	
Pneumonia / Bronchitis	☐	☐	____________	
Emphysema	☐	☐	____________	
Sleep Apnoea	☐	☐	____________	
Cough / Sputum	☐	☐	____________	
Smoker (Past or Current)	☐	☐	____________	
Other Conditions	☐	☐	____________	

METABOLIC / ENDOCRINE	**YES**	**NO**	**Specify…**	**Family History** ☐
Diabetes	☐	☐	____________	
Thyroid Disorder	☐	☐	____________	
Liver Disease	☐	☐	____________	
Other Condition	☐	☐	____________	

URINARY	**YES**	**NO**	**Specify…**	**Family History** ☐
Incontinency	☐	☐	____________	
Difficulty Passing Urine	☐	☐	____________	
Urgency / Frequency	☐	☐	____________	
Frequent UTI's	☐	☐	____________	

REPRODUCTIVE	**YES**	**NO**	**Specify…**	**Family History** ☐
Gynaecological Problems	☐	☐	____________	
Other Problems	☐	☐	____________	
If Female Currently Pregnant?	☐	☐	____________	
Currently Breastfeeding?	☐	☐	____________	

GASTROINTESTINAL	**YES**	**NO**	**Specify…**	**Family History** ☐
Incontinency (Faecal)	☐	☐	____________	
Stoma-ileostomy / Colostomy	☐	☐	____________	
Constipation	☐	☐	____________	
Irritable Bowel Syndrome	☐	☐	____________	
Diverticular Disease	☐	☐	____________	
Ulcerative Colitis / Crohns	☐	☐	____________	
Ulcers	☐	☐	____________	
Hiatus Hernia / Reflux	☐	☐	____________	
Other Conditions	☐	☐	____________	

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BLOOD DISORDERS	**YES**	**NO**	**Specify…**	**Family History** ☐
Bleeding or Clotting Tendencies	☐	☐	________________	
Anaemia	☐	☐	________________	
Other Conditions	☐	☐	________________	

SKIN DISORDERS	**YES**	**NO**	**Specify…**	**Family History** ☐
Skin Disorder (Eczema / Psoriasis)	☐	☐	________________	

MUSCULOSKELETAL	**YES**	**NO**	**Specify…**	**Family History** ☐
Osteo / Rheumatoid Arthritis	☐	☐	________________	
Osteoporosis	☐	☐	________________	
Fractures	☐	☐	________________	
Soft Tissue Injuries	☐	☐	________________	
Gout	☐	☐	________________	
Bone Disease	☐	☐	________________	
Other Conditions	☐	☐	________________	

AUTOIMMUNE DISEASE	**YES**	**NO**	**Specify…**	**Family History** ☐
Speech / Swallowing Difficulties	☐	☐	________________	
Vision Impairment	☐	☐	Glasses ☐ Contacts ☐ Prosthesis ☐	
Hearing Impairment	☐	☐	Hearing Aid ☐ ________	
Language Spoken			________________	

IMMUNISATIONS	**YES**	**NO**	**Date Administered** (if known)
Childhood			
2 Months	☐	☐	___ / ___ / ______
4 Months	☐	☐	___ / ___ / ______
6 Months	☐	☐	___ / ___ / ______
12 Months	☐	☐	___ / ___ / ______
18 Months (born after 2012)	☐	☐	___ / ___ / ______
4 Years	☐	☐	___ / ___ / ______
Adult			
Tetanus	☐	☐	___ / ___ / ______
Flu Vax	☐	☐	___ / ___ / ______
Pneumonia	☐	☐	___ / ___ / ______
Cervical Vaccine	☐	☐	___ / ___ / ______

MEDICATIONS

Drug and Form	Strength	Dosage	Frequency

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ALLEGIES / SENSITIVITIES	**YES**	**NO**	**Specify…**
Drugs	☐	☐	____________________
Foods	☐	☐	____________________
Other Allergies	☐	☐	____________________

DIET / LIFESTYLE	**YES**	**NO**	**Specify…**
Drink Alcohol	☐	☐	____________________
Other Drugs	☐	☐	____________________

Usual Diet (circle) Normal Vegetarian Cardiac Diabetic Low Fat

PREVIOUS OPERATIONS / PROCEDURES:

____
____
____
____
____
____
____
____
____
____

PAST MEDICAL HISTORY

ONCOLOGY	**YES**	**NO**	**Specify…**	**Family History ☐**
Do you have Cancer?	☐	☐	____________________	

TREATMENT	**YES**	**NO**	**Specify…**
Surgical Removal of Cancer	☐	☐	____________________
Radiotherapy / Chemotherapy	☐	☐	Last Radiotherapy: ___ / ___ / ______
			Last Chemotherapy: ___ / ___ / ______
Pharmacological Treatment	☐	☐	____________________
Palliative	☐	☐	____________________

PSYCHOLOGICAL	**YES**	**NO**	**Specify…**	**Family History ☐**
Anxiety / Depression	☐	☐	____________________	
Psychological Disorder	☐	☐	____________________	

NEUROLOGICAL	**YES**	**NO**	**Specify…**	**Family History ☐**
CVA / TIA	☐	☐	____________________	
Parkinson's Disease	☐	☐	____________________	
Epilepsy / Seizures	☐	☐	____________________	
Migraines / Headaches	☐	☐	____________________	
Sleeping Problems	☐	☐	____________________	
Chronic Pain	☐	☐	____________________	
Dementia / Memory Loss	☐	☐	____________________	