WE RESPECT YOUR PRIVACY

In order to provide you with the highest standard of medical care, Redcliffe & Northside Rheumatology is required to collect personal information from you. This information covers details including your name, address, telephone number and email. It is also necessary for the doctor to obtain from you details regarding your general health and past medical surgical events. This general health picture will allow the treating doctor to plan your care properly.

Some of this information may be of a personal nature and/or sensitive so you would not wish it to be unnecessarily disclosed to others.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Medical Association, we would like to assure you that:

. This information will only be used by the treating doctor in order to deliver your care to the highest standards.

. It will not be disclosed to those not associated with your treatment, without your express consent.

. You may seek access to the information held about you and we will provide this access without undue delay. This access may be by inspection of your medical records at the time of appointment or by special access or copying of information at other times.

. We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date.

. We will take reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure.

. Our staff are trained to respect these principles at all times.

. If you consent to correspondence or results being sent via **email** please be aware of the **inherent risks associated with this.**

If you have any questions regarding the information we collect from you and hold in your medical records, please do not hesitate to ask us. We are acting in your best interests at all times.

I have read and understood this privacy policy:

Date:_____ Name: _____ Signature: _____

Redcliffe & Northside Rheumatology
Unit 2/93 Marine Parade
PO Box 534, REDCLIFFE QLD 4020
reception@rheumatologynorthside.com.au Revised July 2022

Personal Details:

Full Name:	Date of Birth:
Gender: Male / Female / Other (Please Circle)	
Address:	
Telephone: (H) (Mobile)	SMS - Yes or No (Please Circle)
Email:	Permission to use email – Yes or No (Please Circle)
Medicare No: Ref:	Expiry Date:
Do you have a pensioner concession card: If so: Number	Exp Date
DVA No: Gold or White (Please Circle)	Expiry Date:
Do you identify yourself as an Aboriginal or Torres Strait Islander?	

Emergency Contact: Permission to contact in case of emergency ❑ Yes or ❑ No

Name:	Relationship to you:
Phone:	

Referring Doctor: (All requested details ESSENTIAL)

Name:
Address:
Phone:

Name of regular GP - if different to above: (All requested details ESSENTIAL)

Name:
Address:
Phone:

CURRENT Specialists: (All requested details ESSENTIAL)

Name:
Address:
Phone:

Name:
Address:
Phone:

Name:
Address:
Phone:

What disease or symptoms are you being referred for?

Major Illness, Hospitalisations and Surgeries:

Description:	*Year:*

Medications List (or attach list) PLEASE INCLUDE CURRENT DOSE

Please include as needed medication i.e. puffers, creams, injections or infusions.

Medication	*Dose*

Have you received any COVID-19 Vaccinations?: ❑ Yes or ❑ No If Yes how many: _____

Known Allergies: _____

Please tick ☑ if you have ever had the following: (If you answer YES to any, please indicate your age at the time or the year it commenced.)

Description:	*Yes*	*Age/Year Commenced*	*Description:*	*Yes*	*Age/Year Commenced*
Ankylosing Spondylitis			Asthma		
Rheumatoid Arthritis			Bowel problems		
Psoriatic Arthritis			Cancer		
Gout			Depression/anxiety		
Lupus/SLE			Diabetes		
Osteoarthritis			Emphysema/COPD		
Other Arthritis			Heart attack/Heart disease		
Other autoimmune or connective tissue disease			High blood pressure		
			High cholesterol		
Broken bones after age 50			Kidney problems		
Fibromyalgia			Severe Allergies		
Back/spine problems			Skin cancer		
Psoriasis			Stomach ulcer/reflux/GORD		
Osteoporosis			Stroke/TIA		
Dry eyes/mouth			Thyroid problems		
Iritis/uveitis			Other		
Blood Clots					
Miscarriages/female					

Family Medical History (if known): Please tick ☑ if there is family history of the following:

	Mother	*Father*	*Brother /Sister*	*Sons/Daughters*	*Other*
Conditions:					
Rheumatoid Arthritis					
Lupus/SLE					
Crohn's/Ulcerative Colitis					
Osteoporosis					
Ankylosing Spondylitis					
Psoriasis					
Other: Please specify					
If deceased, age at death:					
Cause of death:					

Social History:

Current occupation:
If retired, previous occupation:
Have you ever smoked? Yes or No (Please Circle) Do you currently smoke? Yes or No (Please Circle) If YES, how many cigarettes per day? If NO, but have in the past when did you cease?
Have you ever drunk alcohol? Yes or No (Please Circle) Do you currently drink alcohol? Yes or No (Please Circle) If YES, how many drinks per day? If NO, but have in the past when did you cease?
Marital status: Single Married Divorced Widowed Separated (Please Circle)
If married, health of spouse: Good Poor (Please Circle) If poor, please give details:
How many children have you had?
Health of others at home: Good Poor (Please Circle) If poor, please give details:

The details given above are true and correct:

_____ _____

Date: Signature: