



Skip This Part. Medic At Work Office Use Only.

CLIENT NAME:	PATIENT RESULTS:	DATE: / /
CLIENT LOCATION:	BLOOD PRESSURE:	HEIGHT: cm
MEDIC ASSISTANT:	CHOLESTEROL:	WEIGHT: kg
	GLUCOSE:	BMI:

BEFORE WE GET STARTED, YOUR PERSONAL DETAILS PLEASE (MANDATORY)!

SALUTATION: MR MRS MS MISS DR	PHONE:
FIRST NAME:	MOBILE:
SURNAME:	<i>Your regular General Practitioners details or one seen in the past two years:</i>
DOB:	GP NAME:
ADDRESS:	GP CLINIC NAME:
SUBURB:	GP ADDRESS:
STATE: POSTCODE:	GP SUBURB:
EMAIL:	GP PHONE:

ON A SERIOUS NOTE!

Medic At Work respects your right to privacy and aim to protect all personal details provided by securely storing information collected during your consultation. It is important that you understand the purpose for which we collect details about your health, as well as how this information is used.

1. The information collected will only be used for the purpose of providing treatment to you. Personal information such as your name, address and contact numbers will be used for the purpose of addressing mail to you, utilising our recall system, and following up if review with an appropriate health care provider has been undertaken.
2. We may disclose your health information to other health care professionals, or require it from them to assist in any ongoing care or follow up.
3. We may also use parts of your de-identified health information for research purposes, in study groups or at seminars as this may provide a benefit to other patients.
4. Your Medical records and personal information will be stored in confidentially as per our privacy guidelines and accreditation standards of General Practice.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly. You can be assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of Medic At Work, without your consent.

I (please print name) _____ have read and understood the above privacy policy, and consent to the use of my health information in this way.

SIGNATURE: _____

DATE: / /



LET'S TALK HEART, HYPERTENSION & LIFESTYLE!

You will notice below that we are not only interested in your personal health but your family's health too! This is because family history can increase our chances of developing the same condition. No need to fear, you can lower the risk by speaking to your Doctor, taking part in regular health checks and implementing a healthy lifestyle.

DURING YOUR HEALTH CHECK CONSULTATION, WILL YOU BE PARTICIPATING IN THE FOLLOWING BLOOD TESTS?					
GLUCOSE (BLOOD SUGAR) TEST:	YES	NO	CHOLESTEROL TEST:	YES	NO
IF YES, WHEN WAS THE LAST TIME YOU:					
ATE FOOD? _____ AM/PM		DATE: _____			
DRANK LIQUID? (EXCEPT WATER) _____ AM/PM		DATE: _____			
<i>Medic Assistant Use Only (please initial once test complete):</i>					

DO YOU OR YOUR FAMILY HAVE HISTORY OF HEART DISEASE?					
PERSONAL:	YES	NO	FAMILY:	YES	NO
<i>If yes, please explain:</i>			<i>If yes, please explain:</i>		
HAVE YOU HAD ANY OF THE FOLLOWING?					
HEART ATTACK			STENT		
BYPASS			ANGINA		
OTHER (PACEMAKER ETC.)					

DO YOU HAVE FAMILY HISTORY OF THE FOLLOWING CONDITIONS?					
HIGH BLOOD PRESSURE			HIGH GLUCOSE (BLOOD SUGAR)		
HIGH CHOLESTEROL			DIABETES		
<i>IF YES TO ANY OF THE ABOVE, PLEASE ADVISE RELATIONSHIP E.G. (PARENTS, SIBLINGS, RELATIVES)</i>					

HAVE YOU PREVIOUSLY BEEN TESTED FOR ANY OF THE FOLLOWING CONDITIONS?					
HIGH BLOOD PRESSURE			HIGH GLUCOSE (BLOOD SUGAR)		
HIGH CHOLESTEROL			DIABETES		
<i>If yes to any of the above, please advise when?</i>					
	<12 MONTHS	1 – 2 YEARS	2+ YEARS		



HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?	
HIGH BLOOD PRESSURE	HIGH GLUCOSE (BLOOD SUGAR)
HIGH CHOLESTEROL	DIABETES
<i>If yes to any of the above, are you taking any medication?</i>	YES NO
<i>Please advise:</i>	

DO YOU CURRENTLY SMOKE?	
YES	NO
<i>If yes, please explain how often (e.g. socially, daily etc.)</i>	

HAVE YOU PREVIOUSLY SMOKED?	
YES	NO
<i>If yes, when did you stop?</i>	

DO YOU DRINK ALCOHOL?	
YES	NO
<i>If yes, how often?</i>	
NUMBER OF GLASSES PER DAY?	1 – 2 2 – 3 3 – 4 4+ OTHER:
NUMBER OF GLASSES PER WEEK?	1 – 2 2 – 3 3 – 4 4+ OTHER:

DO YOU REGULARLY EXERCISE (WEEKLY)?			
YES	NO	OCCASSIONALLY	3+ TIMES PER WEEK



LET'S TALK EYES!

Since many general health conditions can be associated with eye health conditions, it is important for us to have a clear understanding of your general health and family history.

DURING YOUR HEALTH CHECK CONSULTATION, WILL YOU BE PARTICIPATING IN THE RETINAL (EYE) SCREEN?	
YES	NO
<i>Medic Assistant Use Only (please initial once test complete):</i>	

DO YOU HAVE FAMILY HISTORY OF THE FOLLOWING CONDITIONS?	
DIABETES	CATARACTS
GLAUCOMA	STROKE
MACULAR DEGENERATION	OTHER

HAVE YOU NOTICED A CHANGE IN YOUR VISION IN THE PAST 12 MONTHS?	YES	NO
--	-----	----

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?	
CATARACTS	MACULAR DEGENERATION
GLAUCOMA	STROKE
EYE INJURY	OTHER
MIGRAINES	

HAVE YOU HAD EYE SURGERY?	YES	NO
----------------------------------	-----	----

DO YOU CURRENTLY WEAR GLASSES?	READING ONLY	REQUIRED FULL TIME	
DO YOU WEAR CONTACT LENSES?	YES	NO	OCCASIONALLY
<i>If yes to the above, do you experience one or more of the following after extended use?</i>			
EYE FATIGUE	HEADACHES	DRY OR SORE EYES	

WHEN WAS YOUR LAST EYE EXAMINATION?	NEVER	<12 MONTHS	1 – 2 YEARS
	2 – 3 YEARS	4+ YEARS	OTHER
WAS THIS DONE BY AN OPTOMETRIST OR OPHTHALMOLOGIST? <i>(Please include their name if known)</i>			

DO YOU HAVE FAMILY HISTORY OF SEIZURES OR EPILEPSY?	YES	NO	UNSURE
DO YOU HAVE PREVIOUS HISTORY OF SEIZURES OR EPILEPSY?	YES	NO	UNSURE
<i>If yes, please explain:</i>			



LET'S TALK ABOUT THE BODY'S LARGEST ORGAN, YOUR SKIN!

WHAT IS THE MAIN REASON FOR ATTENDING A SKIN CHECK TODAY?	
WORRIED ABOUT A SPECIFIC SPOT/MOLE ?	FAMILY HISTORY OF MELANOMA?
FOR GENERAL CHECK UP OF SKIN?	HIGH RISK?

WHEN WAS YOUR LAST SKIN CHECK ASSESSMENT?			
<12 MONTHS	1-2 YEARS	2+ YEARS	NEVER

WHERE WAS YOUR LAST SKIN CHECK ASSESSMENT PERFORMED?	
WORKPLACE EXAMINATION?	SKIN CANCER CLINIC?
GENERAL PRACTITIONER?	SPECIALIST DERMATOLOGIST?

WAS THE SKIN CHECK ASSESSMENT A:	FULL BODY CHECK	PARTIAL OR SPOT CHECK ONLY
---	-----------------	----------------------------

HAVE YOU NOTICED ANY NEW / CHANGING MOLES OR SPOTS:	YES	NO	UNSURE
<i>IF YES, PLEASE LIST LOCATION/S:</i>			

HAVE YOU PREVIOUSLY BEEN DIAGNOSED WITH MELANOMA?	YES	NO
<i>IF YES, PLEASE ADVISE: LOCATION OF MELANOMA? AGE AT TIME OF DIAGNOSIS?</i>		

DO YOU HAVE FAMILY HISTORY OF MELANOMA?	YES	NO
<i>IF YES PLEASE ADVISE RELATIONSHIP E.G. (PARENTS, SIBLINGS, RELATIVES)</i>		

HAVE YOU PREVIOUSLY BEEN DIAGNOSED WITH NON-MELANOMA SKIN CANCER?	
YES - BCC (BASAL CELL CARCINOMA)	NO
YES - SCC (SQUAMOUS CELL CARCINOMA)	UNSURE

HAVE YOU PREVIOUSLY RECEIVED TREATMENT FOR SUN-DAMAGED SKIN OR SOLAR KERATOSIS (SUNSPOTS)?		
<i>E.G. CRYOTHERAPY OR FREEZING TREATMENT)?</i>		
YES	NO	

HAVE YOU PREVIOUSLY BEEN SUNBURNT?	
NEVER	SOMETIMES
RARELY	REGULARLY



DO YOU SPEND TIME OUTDOORS (WORK / RECREATIONAL)?	
YES, 1+ HOUR EACH DAY	NO, INDOOR ONLY / MINIMAL

HAVE YOU PREVIOUSLY USED A SOLARIUM OR TANNING BED?	
YES	NO
<i>If yes, please explain how often at the time E.G. frequent or occasional?</i>	

ARE YOU ON ANY MEDICATION FOR AN AUTOIMMUNE CONDITION?	
YES	NO
<i>If yes, please advise medication?</i>	

WHAT IS YOUR NATURAL HAIR COLOUR?			
RED	BLONDE	BROWN	BLACK

WHAT COLOUR ARE YOUR EYES?				
BLUE	BROWN	GREEN	HAZEL	GREY