OLYMPUS MEDICAL CENTRE
OLYMPIC PARK

Australia Towers Ground Floor, 5 Australia Avenue, Sydney Olympic Park NSW 2127
T (02) 9746 3377 F (02) 9318 7311 E op@olympushealthgroup.com.au W olympusmedicalop.com.au

Please circle: Mr / Mrs / Ms / Miss / Dr / Prof

Surname: ____________________________ Given Name/s: ______________________________ Date of birth: ___ / ___ / ____

Address: ________________________________________________ Suburb: _________________________ Postcode: _________

Occupation: ___________________ Language spoken at home: _________________ Marital Status: ____________________

Medicare Number: ________________________ / _____ Health Care Card / Pension Card No. ____________________________

If applicable: DVA Number __________________________ Workcover Claim Number: __________________________________

Do you identify as ATSI? Yes / No Are you an elite athlete governed by World Anti-Doping Agency? Yes / No

If applicable: Are you pregnant? Yes / No / Unknown Are you breastfeeding? Yes / No

## EMERGENCY CONTACT DETAILS

There may be emergencies when we are legally required to contact you (e.g. to advise of life-threatening results) or to notify a loved one that you are critically unwell. Please provide as many contact details as possible to avoid unnecessary delays. None of the following will be used for marketing purposes or shared with third parties.

Phone number(s): ___________________________________ Email address: ____________________________________________

Emergency contact: Name: _________________________ Relationship to you: _______________ Phone: __________________

## REMINDERS / RECALLS / ANNOUNCEMENTS

Olympus Medical Centre can send you reminders about your health (e.g. when you're due for blood tests) and/ or advise you about important news about the practice (e.g. we'll be closed for holidays next week). We will never contact you with advertising material or share your details with third parties. This service is entirely optional.

I would like to receive: reminders about my own health / important news about the practice / nothing at all

## HEALTH INFORMATION

Usual / Previous GP Name: _______________________________________ Suburb: ___________________________________

Do you intend to make Olympus Medical Centre your regular GP / Nominated Treating Provider? Yes / No

Other healthcare providers involved in your care: Specialists, Physio, Chiropractor, Psychologist, Naturopath etc

| Name | Medical Condition Treated | Suburb | Phone |
| --- | --- | --- | --- |
| | | | |

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**DO NOT COMPLETE THIS PAGE IF YOU HAVE A HEALTH SUMMARY FROM YOUR PREVIOUS GP**

## MEDICATIONS:

| Medication Name | Strength | Dose | Frequency |
|---|---|---|---|
| (e.g. Metformin) | (e.g. 500mg) | (e.g. 2 tablets) | (e.g. twice daily) |

## ALLERGIES / ADVERSE REACTIONS:

| Allergen | Reaction |
|---|---|
| | |

**MEDICAL HISTORY:** – please circle any current, or previous, medical conditions.

| | | | | |
|---|---|---|---|---|
| High blood pressure | High cholesterol | Heart attack | Heart Bypass / Stent | Pacemaker |
| Asthma | COPD / Emphysema | Hayfever | Pneumonia | Sleep apnoea |
| Headaches | Migraines | Epilepsy / Seizures | Stroke / TIA | Mental Health Diagnoses |
| Diabetes | Thyroid Disorder | Autoimmune Disease | Liver Disease | Bleeding disorder |
| Gastroesophageal Reflux Disease | Coeliac Disease / Gluten intolerance | Bowel Disease (IBD/ IBS) | Gallstones | Bowel Polyps |
| Urinary Tract Infections | Kidney Stones | Incontinence | Sexually Transmitted Infections | AIDS / HIV |

Use the following space for further detail about the above diagnoses, or, conditions not listed above.

| Diagnosis | Year of diagnosis | Still active? (Y / N) |
|---|---|---|
| | | |

## FAMILY HISTORY:

| Relationship to you | Diagnoses (and age when diagnosed) | Still alive? (Y / N) |
|---|---|---|
| (e.g. Paternal grandfather) | (e.g. Hypertension (50s), high cholesterol (50s), Stroke (96)) | |