Bayside Skin Cancer & Medical Clinic
Patient Information Form

Welcome to the Bayside Skin Cancer & Medical Clinic

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Please assist us by completing the following

PERSONAL DETAILS	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ……
First Name	
Surname	
Preferred Name	
Date of Birth	
Sex	☐ Male ☐ Female

GENERAL

Medicare Number	**Ref** ☐	**Expiry Date**	
DVA Number **Gold / White** (Please circle)		**Expiry Date**	
Pension Card Number		**Expiry Date**	
Health Care Card Number		**Expiry Date**	

CONTACT DETAILS

Residential Address	
Home Phone	
Work Phone	
Mobile Phone	
Email Address	
Postal Address (if different from Residential)	
Next of Kin/Emergency Contact (Name, Contact Phone number & Relationship to Patient)	

USUAL DOCTOR

If you were referred by another doctor and/or would like your results forwarded to your usual GP please complete the following:

Doctor's Name	
Address	
Phone	

How did you hear about our Clinic?

☐ Referred by Another Doctor
☐ Word of Mouth ie Another patient etc
☐ Local Advertising
☐ Yellow Pages
☐ Web/Internet
☐ Other_____

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Name		**Date of Birth**	

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it is collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, photographs and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

Follow up reminder/recall notices for treatment and preventive healthcare.
For accounting procedures and the collection of professional fees.
The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons eg. General Practice Managers.
For legal related disclosure as required by a court of law.
For the purposes of research only where de identified information is used.
To allow medical students and staff to participate in medical training/teaching using only de identified information.
For disease notification as required by law.
For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Patient Name: (Please Print) _____

Signature: _____ Date: _____

If not Patient signing -Your name (Please Print) _____

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A Few Questions About You & Your Skin

Name		Date of Birth	

ALLERGIES: Do you have any allergies or are you sensitive to any drugs or dressings – in particular to medications, antiseptic solutions or sticking plasters?
☐ Yes ☐ No ☐ Unsure
If Yes, details:_____

HEALTH HISTORY: Do you have any medical conditions requiring ongoing treatment or medications?

_____

CURRENT MEDICATIONS :(Especially Aspirin or Warfarin)

_____

SKIN CANCERS:
Have you ever had a skin cancer diagnosed and treated by a doctor?
☐ Yes ☐ No ☐ Unsure
If Yes, what type/s: ☐ SCC ☐ BCC ☐ Solar Keratosis/Sunspot ☐ Other
Have you ever had a malignant melanoma in the past?
☐ Yes ☐ No ☐ Unsure
Is there a family history of malignant melanoma?
☐ Yes ☐ No ☐ Unsure
Do you have a history of other skin cancers in your immediate family?
☐ Yes ☐ No ☐ Unsure
If Yes, who: ☐ Father ☐ Mother ☐ Sibling (Brother/Sister) ☐ Other Relative
What skin type are you?
- ☐ **Skin Type I – Never tans, always burns** (extremely fair skin, blonde hair, blue/green eyes)
- ☐ **Skin Type II – Occasionally tans, usually burns** (fair skin, light hair, green/brown eyes)
- ☐ **Skin Type III – Often tans, sometimes burns** (medium skin, brown hair, brown eyes)
- ☐ **Skin Type IV – Always tans, never burns** (olive skin, brown/black hair, dark brown/black eyes)
- ☐ **Skin Type V – Never burns** (dark brown skin, black hair, black eyes)
- ☐ **Skin Type VI – Never burns** (black skin, black hair, black eyes)

How many times in the past have you been badly sunburnt to peeling?
☐ Never ☐ A Few ☐ Several ☐ Regularly
Do you work in the sun? ☐ Yes ☐ No ☐ Sometimes
Do you have any specific moles, lumps or spots that you would like the doctor to examine?
☐ Yes ☐ No ☐ Unsure
If Yes, please indicate with an X on the body map on the next page

In order to check your skin thoroughly, we recommend a full systematic skin examination rather than just a brief check of a few spots. It is important to be aware that some skin cancers can occur even where the sun does not normally shine! To perform a full skin check, we ask that all clothing is removed down to your underwear. Please discuss with the doctor if there are any areas of concern under your underwear.

Please tick what type of skin check you would like from the following:
☐ Full Skin Check ☐ Spot Check following areas:_____

Signature:_____ Date:_____

Name		**Date of Birth**