

**Title \***

Mr  Mrs  Ms  Miss  Master  Dr  Other

**Other****Surname \*****First and Middle Names \*****Date of Birth \*****Postal Address \*****Suburb \*****State / Territory \*****Postcode \*****Daytime Phone \*****Mobile****Work****Email Address \*****Emergency Contact Person \*****Relationship to Patient \*****Mobile Number \*****Daytime Phone**

Next of Kin As Above

**Next of Kin \*****Relationship to Patient \*****Mobile Number \*****Daytime Phone**

Other

Medicare	DVA Number
Reference Number (next to name)	Card Expiry
Pension or Centrelink Health Care Card Number	Card Expiry
Private Health Insurance	Membership Number

To whom should the account be addressed if the patient is a child

Name

Date of Birth

## Medical Information

Allergies \*

Yes  Nil known

Allergy / Intolerances

Reaction

Severity

Please tick any relevant past medical / surgical history

Heart Disease  High Blood Pressure  High Cholesterol  Diabetes  Cancer  Migraine  Asthma  
 Stomach or duodenal ulcer  Epilepsy  Depression / Anxiety

Other illness / surgery - please give details

Please list current medications, including vitamins and mineral supplements

Medication name + dose

Please include the dose and frequency

Immunisations

Pneumococcal (pneumonia)  Influenza  Tetanus  Covid-19  Other

Please specify

## Family History

Have any of your close relatives had heart disease before 60 years of age? Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery. \*

Yes  No

Have any of your close relatives had diabetes? Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes. \*

Yes  No

Do you have any close relatives who had inflammatory bowel disease (Crohn's or Colitis)? \*

Yes  No

Have any of your close relatives had bowel cancer before 55 years of age? \*

Yes  No

Do you have more than one relative on the same side of the family who had bowel cancer at any age? Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren. \*

Yes  No

Have any of your close relatives had liver disease or cirrhosis? \*

Yes  No

Have any of your close relatives had a stomach or duodenal ulcer or H.pylori? \*

Yes  No

If there is a family history of cancer, please specify what kind:

## Lifestyle Health History

Smoking history \*

Never smoked  
 Former smoker  
 Current smoker

Quit date

Cigarettes / day

No. of years smoking

Do you drink alcohol? \*

Yes  
 No

Drinks per day

Drinks per week

# Health Information Collection and Use Consent Form

Sydney Gastroenterology and Liver Group respects your right to privacy and we are mindful that the information that you provide to us is **personal and private**. As a patient or client of this service, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. As part of your consultation, we use i-Scribe, an AI assisted medical dictation tool that is compliant with Australian Health Regulations for transcription of notes and correspondence. No audio is recorded or stored.

We aim to protect the privacy and secure storage of your health information. No information about you, including the fact that you have attended for a consultation or procedure will be released to anyone outside of the service without your **written permission** except in certain circumstances (eg. **legal related disclosure**). You can request a copy of our Privacy Policy, which includes information about the collection, use and disclosure of your health information as well as how to access your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors, counsellors and specialists outside this medical practice. This may occur through referral to other doctors, specialists or allied health professionals, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors (including specialists), locums, registered nurses, medical students etc. for the specific purpose of education, patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. In most circumstances, information that does not identify you is used, but should information that will identify you be required, you will be informed and given the opportunity to "opt out".
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder or recall letters which may be sent to you regarding your health care and management.
- For **legal related disclosure** as requested by a court of law (eg. Subpoena, court order, suspected child abuse or non-accidental physical injury, or in circumstances where we have cause to be seriously concerned for your safety or anyone else)

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you. If you have any concerns about the above information. Or wish to restrict access to your personal health information please discuss this with your doctor at the time of consultation.

For further enquiries, please contact T: (02) 9480 6210 F: (02) 8008 1625 E: [admin@gastroandliver.com.au](mailto:admin@gastroandliver.com.au)

Signature \*

Date

Sydney Gastroenterology and Liver Group

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Sydney Adventist Hospital  
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Wahroonga NSW 2134

(02) 9480 6210

[admin@gastroandliver.com.au](mailto:admin@gastroandliver.com.au)