

# KENMORE SKIN CANCER CLINIC

## Patient Registration Form

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.

<b>Title</b> (please circle)	Mr	Mrs	Ms	Miss	Mst	Dr	Other .....
<b>First Name</b>							
<b>Surname</b>							
<b>Preferred Name</b>							
<b>Date of Birth</b>							<b>Country of Birth:</b>
<b>Sex</b>	Male	Female					
<b>Marital Status (please circle)</b>	Single	Married	Widowed	Divorced	Defacto	Separated	
<b>Medicare Number</b>				<b>Ref</b> <input type="checkbox"/>	<b>Expiry Date</b>		
<b>Concession Card – Issued by Centrelink</b>							
Pension Card Number					<b>Expiry Date</b>		
Health Care Card Number					<b>Expiry Date</b>		
DVA - Gold / White					<b>Expiry Date</b>		
Seniors Health Card (Discount consultation rate)					<b>Expiry Date</b>		
<b>Occupation</b>							
<b>Residential Address</b>							
<b>Home Phone</b>					<b>Mobile</b>		
<b>Email</b>							
<b>Postal Address (if different from Residential)</b>							
<b>Next of Kin</b>	Name:			D.O.B:			
	Phone:						
	Relationship:						
<b>Emergency Contact</b>	Name:						
<input type="checkbox"/> Same as Next of Kin	Phone:						
<input type="checkbox"/> Other - complete →	Relationship:						
<b>USUAL DOCTOR</b>	If you were referred by another doctor and/or would like your results forwarded to your usual GP please complete the following:						
<b>Doctor's Name</b>							
<b>Address</b>							
<b>Phone</b>							

### Health Initiatives:

Are you?  Yes, of Aboriginal origin  Yes, of Torres Strait Islander origin  
 Yes, of both Aboriginal & Torres Strait Islander origin  No, none of the these

Do you have a My Health Record?  Yes  No  Unsure

Do you wish to transfer your regular care to our practice?  Yes  No  Unsure

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Name		Date of Birth	
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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) \_\_\_\_\_

*Staff use only:*

- Data entry complete                      Chart #:  SKIN                       MD                       ODP
- Concession card verified
- My Health Record Brochure (if required)
- Patient Transfer Form (if required)
- Checked and complete by Staff (Staff Initials) \_\_\_\_\_

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<b>Name</b>		<b>Date of Birth</b>	
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**HEIGHT:** \_\_\_\_\_ **cm**      **WEIGHT:** \_\_\_\_\_ **kg**

**ALLERGIES:** Do you have any allergies or are you sensitive to any drugs or dressings?

Yes       No       Unsure

If Yes, details: \_\_\_\_\_

**SOCIAL HISTORY:**

Smoke       Non Smoker

Ex Smoker    Yr started \_\_\_\_\_      Yr stopped \_\_\_\_\_

Light (<5/day)    Mod (5-20/day)    Heavy (>20/day)

Smoker      /Day \_\_\_\_\_      Yr started \_\_\_\_\_

Drink Alcohol    Non drinker

Drinker    Days/week you consume alcohol? \_\_\_\_\_ How many drinks/day? \_\_\_\_\_

**SIGNIFICANT FAMILY HISTORY:**

Nil known       Unknown

Mother       Diabetes       Hypertension       Heart Disease       Stroke

Colon Cancer       Depression       Breast Cancer

Father       Diabetes       Hypertension       Heart Disease       Stroke

Colon Cancer       Depression       Prostate Cancer

**PERSONAL HEALTH HISTORY:** Do you have or had a history of?

Diabetes       Hypertension       Heart Disease       Asthma       Cholesterol

Any other Chronic Disease \_\_\_\_\_

Cancer/tumour (of any type) \_\_\_\_\_

Operations/procedures/minor surgery \_\_\_\_\_

Other \_\_\_\_\_

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*Doctor/Staff use only:*

Reviewed by GP (GP Initials) \_\_\_\_\_

Data Entry checked and complete by Staff (Staff Initials) \_\_\_\_\_

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### A Few Questions About You & Your Skin

Name		Date of Birth	
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**What skin type are you?**

- Skin Type I – Never tans, always burns**  
(extremely fair skin, red or blonde hair, blue/green eyes)
- Skin Type II – Tans slightly, usually burns**  
(fair skin, freckles, red or light hair, blue/green/hazel eyes)
- Skin Type III –Tans gradually after initial burn**  
(darker cream white skin, any eye or hair colour)
- Skin Type IV –Tans easily, minimally burns**  
(olive / brown skin, brown/black hair, green/hazel/brown eyes)
- Skin Type V – Rarely burns, tans darkly easily**  
(dark brown skin, dark brown or black hair, dark brown eyes)
- Skin Type VI – Never burns**  
(black skin, black hair, dark brown/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

**Have you been exposed to arsenic through work eg cattle dips, industry?**

- Yes                       No                       Unsure

**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

**Do you have any specific moles, lumps or spots that you would like the doctor to examine?**

- Yes                       No                       Unsure

**Details:**

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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.