My Health Now

**Caboolture & Kilcoy Hospitals**

*Your health information in your hands when you need it*

**\*Delete this box when you have filled in this form\***

How to use this form:

* Fill in the sections that relate to you (don’t delete anything – if it’s not relevant, put N/A.)
* Add extra lines if you need to
* Print and keep copies with you and in your home where you can find them easily
* Consider giving copies to your loved ones or emergency contacts
* Save it to your computer/phone and email it to yourself

*This form is not a legal or medical document and is intended for personal use only. The form will only be stored on a patient's medical record at the request and consent of the patient. Once completed, this form contains personal information and health information within the meaning of the definitions as provided by Schedule 5 of the Information Privacy Act 2009 (Qld).*

|  |  |
| --- | --- |
| **Today’s date**  |  |

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| --- |
| **About me** |
| **Preferred name** |  |
| **Legal name** |  |
| **Date of birth** |  | **Country of birth** |  |
| **Phone**  |  | **Address** |  |
| **Sex/gender** |  | **Blood type** |  |
| **I am** *(check box)* | **Aboriginal** [ ]  | **Torres Strait Islander** [ ]  | **South Sea Islander** [ ]  | **None** [ ]  |
| **My first language** |  | **I need an interpreter: Yes** [ ]  **No** [ ]  |
| **My culture** *(religion, practices)* |  |
| **I have a** *(please tick and attach)* | **Advance Health Directive** [ ]  | **Statement of** **Choices** [ ]  | **ACAT** **Assessment** [ ]  |
| **Communication** *(Hearing, vision, or speech challenges, or anything that impacts your communication)* |
|  |
| **Please help me to communicate by** |
|  |

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| **Useful contacts** |
| **My GP** | *Name:* | *Practice:* | *Phone:* |
| **Enduring Power of Attorney** | *Name:*  | *Phone:* |
| **Next of Kin**  | *Name:* | *Phone:* | *Relationship:* |
| **Emergency contact/s** | *Name:* | *Phone:* | *Relationship:* |

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| **My health cards** |
| *Card* | *Number* | *Expiry* | *Card* | *Number* | *Expiry* |
| Medicare |  |  | Australian Organ / Body Donor |  |  |
| DVA  |  |  | Commonwealth Seniors / Pension |  |  |
| **Private health cover** | **Hospital** | **Extras** |
| *Health fund* | *Member number* | *Health fund* | *Member number* |
|  |  |  |  |

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| **About My Health Now** |
| **Allergies** |  |
| **Risk factors** | *Risk factor* | *Impact*  |
|  |  |
| **Chronic conditions**  | *Condition* | *Impact*  |
|  |  |
| **Mental health conditions** | *Condition* | *Impact*  |
|  |  |
| **Special diet** |  |
| **Aids***Mobility or other* |  |

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| **Current medications** (or attach list) |
| *Name* | *Dose* | *Quantity* | *Frequency* | *Reason* |
|  |  |  |  |  |

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| Vaccinations (or attach list) |
| *Vaccine* | *Date* | *Reaction (if any)* |
|  |  |  |
|  |  |  |

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| Medical history  |
| **Childhood** |   |
| **Teens** |  |
| **Adult** |  |
| **Family history**  |  |
| **Accidents/ injuries** |  |
| **Surgery**  | *Year* | *Procedure* |
|  |  |
| **Complex diseases**  | *Type/location* | *Diagnosis date* | *Surgery date* | *Treatment* | *Current state* |
|  |  |  |  |  |