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).*

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| --- | --- |
| **Today’s date** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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* |  | |

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

|  |  |  |
| --- | --- | --- |
| 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* |
|  |  |  |  |  |