PATIENT INFORMATION FORM

TITLE: Mr Master Mrs Ms Miss Dr

GIVEN NAMES (FIRST NAME) ______________________________

SURNAME (FAMILY NAME) ______________________________

ADDRESS: ______________________________

____

______________________ POST CODE: ______________________

TELEPHONE: (Home): ____________________ (Work): ____________________

(Mobile): ______________________________

Email address: ______________________________

DATE OF BIRTH: ____ /_____/_______

PATIENT'S MEDICARE No: ______________________ Ref No: ______________

PRIVATE HEALTH FUND: ______________________________

FAMILY DOCTOR IF DIFFERENT TO REFERRING DOCTOR: ______________________

IF THE PATIENT IS UNDER 16 YEARS OF AGE WE REQUIRE THE FOLLOWING DETAILS:

ACCOUNT HOLDERS NAME: ______________________________
(Parent/Guardian)

ACCOUNT HOLDER'S MEDICARE NO: ______________________Ref No: _______

ACCOUNT HOLDER'S DOB: _______ /_______/_______

TODAY'S DATE: ______________________ SIGNATURE: ______________________

HEALTH DETAILS:

1. DO YOU HAVE ANY MEDICAL PROBLEMS? (Please tick)
   - ☐ Diabetes
   - ☐ Kidney Disease
   - ☐ Asthma
   - ☐ Blood Pressure (High or Low)
   - ☐ Heart Disease
   - ☐ Hepatitis
   - ☐ Lung Disease
   - ☐ HIV
   - ☐ Other ____

2. PLEASE LIST PRESENT MEDICATIONS: ______________________________

   ____

3. LIST PREVIOUS OPERATIONS (including Tonsillectomy and/or Adenoidectomy):

   ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. HAVE YOU BEEN IN HOSPITAL IN THE LAST THREE (3) MONTHS: YES / NO

2. ALLERGIES TO MEDICATIONS: YES / NO - If Yes which?

   ____

3. DO YOU USE CORTISONE (Steroids) BY MOUTH? YES / NO

4. DO YOU SMOKE? YES / NO If yes, how much? ____________________

   If no, have you ever smoked?____________________

   And if so, how much? ____________________

5. DO YOU DRINK ALCOHOL? YES / NO

6. DO YOU HAVE A TENDENCY TO BRUISE OR BLEED EASILY? YES / NO

   DOES ANYONE IN YOUR FAMILY? YES / NO ____________________