



**PATIENT INFORMATION SHEET \*\*CONFIDENTIAL\*\* (See full privacy policy for details)**

Title (please circle): Mr / Mrs / Ms / Miss / Dr / Other.....

Last name..... First name.....

DOB...../...../.....

Address.....

.....

Home Phone..... Work Phone.....

Mobile..... Email.....

Preferred number (please circle): Mobile / Home Phone / Work Phone / Other .....

Preferred contact (please circle): Self / parent or guardian / relative or friend Name.....

Private Health Insurance (please circle): Yes / No Health Fund name.....

Private Health Insurance membership number.....

Medicare number..... Expiry date...../...../..... Reference No.....

Veteran's Affairs number..... Expiry date...../...../.....

Pension number..... Aged / Disability (please circle)

Contact for emergencies..... Phone.....

Relationship.....

Alternate contact for appointment confirmation..... Phone.....

Relationship.....

Would you like us to leave a message with these relatives regarding any appointment or medical related issues?

Yes / No (please circle)

Family doctor (Your GP)..... Phone.....

Address.....

Referring doctor (If different from above)..... Phone.....

Address.....

**PRIVACY POLICY:** Our staff will not disclose this information to any third party. Your information is stored on a secure password protected information system. Onward referral to another specialist will require the duplication of this form, your record and test results. If results are not received by the practice, our staff may call the organisation that performed the tests to receive a fax copy. Your records and information may be kept by your doctor at another location. Your information may be used for billing purposes including bad debt management. If you do not give permission for the above please let our receptionist know. Access to your medical records may be allowed in accordance with the appropriate section of the National Privacy Act 1988.





**PATIENT DATA SHEET**

**\*\*CONFIDENTIAL\*\***

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**MEDICAL HISTORY**

Do you have any other medical problems? Please tick and provide details.

No other medical problems

Tick

<input type="checkbox"/>	Heart (eg Heart attacks, chest pain, bypass, stent).....
<input type="checkbox"/>	Lungs/ Chest (eg Asthma) .....
<input type="checkbox"/>	Brain (eg Stroke) .....
<input type="checkbox"/>	Diabetes.....If Yes, are you treated with: <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets <input type="checkbox"/> Diet alone
<input type="checkbox"/>	Bleeding Problems/ Clotting problems.....
<input type="checkbox"/>	High Blood Pressure.....
<input type="checkbox"/>	Kidney problems.....
<input type="checkbox"/>	Thyroid Problems .....
<input type="checkbox"/>	Liver Problems.....
<input type="checkbox"/>	Cancer treatment.....
<input type="checkbox"/>	Other.....

**PREVIOUS OPERATIONS**

Please list any previous operations/ surgical procedures.....

No previous operations

.....  
.....

**MEDICATIONS**

Are you taking any blood thinning medications?

Not taking any blood thinning medications

<input type="checkbox"/>	Aspirin (Cartia/ Cardiprin/ Dispirin/ Solprin/ Aspro/ Astrix/ Asasantin) .....
<input type="checkbox"/>	Warfarin (Coumadin/ Marevan).....
<input type="checkbox"/>	Clopidigrel (Iscover/ Plavix) .....
<input type="checkbox"/>	Arthritis medications (Non-steroidal anti-inflammatories – eg Voltaren, Ibuprofen, Indocid, Celebrex ).....

**PLEASE TURN OVER**





Please list all other medications you are currently taking.....

Not taking any other medications

.....  
.....  
.....

Please list any drug allergies or medications you cannot take.....

No known drug allergies

.....  
.....

**SMOKING**

Do you smoke now?

Have you smoked in the past?

Never smoked

 Yes  
 No Yes  
 No

If Yes, how much do you smoke now, or in the past, on average?

 2 or more packs per day 1 pack per day A few cigarettes per day

How many years in total have you smoked?.....Yrs

**ALCOHOL**

How many standard drinks do you take?

Never take alcohol

 .....drinks per day OR  .....drinks per week Only on weekends/ social events Very rarely or not at all

**FAMILY HISTORY**

Please list any medical problems that run in the family

No medical problems that run in the family

.....  
.....

**FEMALE PATIENTS**

Are you pregnant?

 Yes No Not sure/ could be

Thank you for filling out this form. Your information will remain confidential (Please see full privacy policy for details)

