

**PATIENT PARTICULARS**

Surname: .....

Given names: .....

Residential address: .....

..... Postcode : .....

Postal address: .....

..... Postcode : .....

Email address: .....

Phone: (Home): ..... (Work):..... (Mobile):..... (can you receive SMSs?)...

Date of birth: ..... Age: .....

Height: ..... cm Weight: ..... kgs

Marital Status: .....

Occupation: .....

Note: If retired enter previous occupation: .....

Note: If patient is a child please enter- Parents full name/s:.....

Parents occupation/s: .....

Next of kin: ..... Relationship.....

Contact phone number: .....

Power of attorney (if applicable) .....

Regular Doctor/GP.....

Medicare 

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 Ref no.(next to your name) 

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 Expiry date.....

Dept of Veteran's Affairs number: ..... Card Colour: .....

Pension or Health Care Card Number: .....

Seniors Health Card Number: .....

Private Health Insurance Hospital Cover: Yes / No If yes :

Full cover with private Dr in a private hospital? ..... Or Intermediate cover with a private Dr in a public hosp? .....

Name of Private Health Fund .....

Membership type (eg Advantage Plus), if stated on card .....

Membership No. ....Reference number (beside your name)eg 01/1.....

*Settlement of Account: PLEASE NOTE: We do not bulk bill – an account will be generated at the time of service. Terms 7 days. Please call 4031 2188 if you have any queries regarding this.*

Cash  Cheque  EFTPOS  Mastercard  Visa

*Please turn to next page*

**PATIENT MEDICAL DETAILS**

1. Previous operations/accidents.

- (a) ..... Year .....
- (b) ..... Year .....
- (c) ..... Year .....

2. Previous/current illnesses.

- (a) High Blood Pressure Yes / No Year diagnosed .....
- (b) High Cholesterol Yes / No Year diagnosed .....
- (c) Heart Problems Yes / No Year diagnosed .....
- (d) Diabetes Yes / No Year diagnosed .....
- (e) Bronchitis Yes / No Year diagnosed .....
- (f) Asthma Yes / No Year diagnosed .....
- (g) Exposure to Asbestos Yes / No When .....
- (h) Other.....

3. Social Habits.

Do you smoke? ..... Year started: ..... How many a day.....  
 Have you smoked previously? ..... Year started: ..... Year ended.....  
 How many a day did you smoke:.....

Do you drink alcohol?.....

How many days a week do you usually drink alcohol?

less than monthly    1-2 days a month    1-2 days a week    3-4 days a week  
 5-6 days a week    every day

How many standard drinks a day?.....

Do you drink six or more standard drinks on one occasion?

Never    Less than monthly    Monthly    Weekly    Daily or almost daily

4. Current medication – Strength and times taken. Also herbal medications & vitamins

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

5. List medications which you are allergic to:

.....

6. Have you taken these medications on a regular basis?

- (a) Pain killer /Headache powders Yes / No .....
- (b) Laxatives /Opening medicines Yes / No .....

7. Family Medical History:

Mother	Age: Age deceased:	Medical/heart condition:
Father	Age: Age deceased:	Medical/heart condition:
Brothers	1.Age: 2.Age: 3.Age:	Medical/heart condition:
Sisters	1.Age: 2.Age: 3.Age:	Medical/heart condition: