# 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

1. PLEASE LIST PRESENT MEDICATIONS:
2. 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?

1. DO YOU DRINK ALCOHOL? YES / NO
2. DO YOU HAVE A TENDENCY TO BRUISE OR BLEED EASILY? YES / NO

DOES ANYONE IN YOUR FAMILY? YES / NO