

Patient Information

First Name (Mr, Ms, Mrs, Miss, Dr): _____ Surname: _____
 Address: _____ Suburb: _____ Postcode: _____
 Sex: Male / Female Date of birth: ____ / ____ / ____ Age: _____
 Telephone: Home: _____ Work: _____ Mobile: _____
 Email Address: _____ Occupation: _____
 Employer Name: _____ For student: Name of Institution: _____
 Driving License number: _____ Medicare Number: _____
 General medical practitioner: _____ Location: _____
 Do you have: Private medical insurance? Yes / No Hospital cover? Yes / No Dental Cover? Yes / No
 Name of health fund: _____ Card number: _____ Patient series (eg. 01): _____
 Who may we thank for referring you? _____

Patient Information

Are you under the care of your doctor at present? Yes / No
 Are you taking any tablets or medicines at the moment? Yes / No If yes, please state: _____
 Are you allergic to any medications or other substances? Yes / No If yes, please state: _____
 Have you been in hospital in the last two years? Yes / No If yes, please give details: _____
 Do you smoke? Yes / No If yes, how much? _____
 Ladies, are you, or might you be pregnant? Yes / No Confinement date: _____

If you have, or have had any of the following conditions, please place a tick in the box

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart attack/Angina | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other disability |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> HIV | |

Details: _____

I have further confidential information which I do not wish to write down. Yes / No

I have completed this form to the best of my knowledge and it represents my medical history accurately. Any changes will be advised at subsequent appointments.

Signed: _____ Date: _____