

Welcome

In order to provide you treatment of a high standard, it is necessary to have the following information to assist us.
All information will be treated with complete professional confidentiality.
Please take your time to answer these questions completely as possible.

MR MRS MS MSt MISS DR SURNAME.....	FIRST NAMES.....	DATE OF BIRTH.....
HOME ADDRESS.....		POSTCODE.....
PHONE HOME.....	MOBILE.....	EMAIL.....
OCCUPATION.....	EMPLOYER.....	PHONE WORK.....
BUSINESS ADDRESS.....		POSTCODE.....
NEXT OF KIN (NOT AT YOUR ADDRESS).....		PHONE.....
ADDRESS.....		POSTCODE.....
PERSON RESPONSIBLE FOR FEES.....		
HEALTH FUND OR BENEFIT MEMBERSHIP.....		
MEDICARE NUMBER.....		EXPIRY.....REF No.....

REFERRAL

Who may we thank for referring you to our practice? Another patient - name.....

Sign outside Internet Newspaper Referral by a doctor, dentist or chemist Other.....

MEDICAL HISTORY

FAMILY HISTORY: Tick any of the following conditions from which any member of your family has suffered:

Diabetes Asthma Heart Disease Blood Pressure Cancer Tuberculosis Other.....

PERSONAL HISTORY: Do you have or have you had any of the following? Please tick:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Head injuries	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Cancer/Tumour	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart/vascular disease	<input type="checkbox"/> Radiation therapy
<input type="checkbox"/> Artificial knee/hip/shoulder joint	<input type="checkbox"/> Deafness	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Hiatus hernia	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Abnormal bleeding (excessive)	<input type="checkbox"/> Earaches	<input type="checkbox"/> Immune deficiency	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Skin trouble
<input type="checkbox"/> Blood pressure - high	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney/bladder disease	<input type="checkbox"/> Sleep apnoea
<input type="checkbox"/> Blood pressure - low	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Mouth ulcers	<input type="checkbox"/> Thyroid problems
	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Ulcers

Are you in a high risk group for Hepatitis or HIV infections?

No Yes Don't know

Do you have allergies or bad reactions to anything?

No Yes penicillin codeine anaesthetic
 latex/gloves Other.....

List any drugs, medications or supplements taken in the last 2 weeks & reasons:.....

Have you been in hospital or had any operations in the last 2 years?

No Yes

Are you under current medical treatment by a doctor/specialist?

No Yes

Who is your usual medical doctor? Telephone.....

How do you rate your general health?

Perfect Good Fair Poor

What is the date of your last physical examination?

.....

Are you pregnant (females)?

No Yes - months.....

Do you smoke?

No Yes - how many per day.....

Do you drink alcohol?

No Yes

Please list any other conditions that this practice should be made aware of:.....