**New Patient Questionnaire**

**Personal Information**

Name: ...……………………………………………………………………………………………………………………………………………………………...........................

Address: …………………………………………………………………………………………………………………….… Post Code: ..………………………………….

Date of birth: ………………………………………………..… Occupation: ………………………….…….………..…………………………………………………….

Phone: ……………………..………… Mobile: …………….…................................... Email: ………………………...……….………………………………………….

Next of Kin: …………….…............................................................. Next of Kin Contact: ………………………...……….………………………………………….

**Medicare / Health Fund Details**

Medicare Number: ……………………………………………………………...…….…… Ref no: ………….… Expiry: ……………………………………………..

Private Health Fund: ……..………………….…………………………………….………. Ref number: ………………………………………………………………

DVA Number: …………………………………………………………………………...…… Card Colour: ….…….............................................................................

**Referring Doctor Information**

Referring Doctor: ..…………………………………...… Address: ………………………………..…………………….………………………………………..……….

GP name: ………..……………………………...…………… Address: ...…………..………………………..…………..……………………………………………………

**Confidential Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| High blood pressure……………..…………….. | Y N | Heart disorder……………..………..…………….. | Y N |
|  |  |  |  |
| Diabetes…………………………………………….. | Y N | Stomach ulcer……….........................……………. | Y N |
|  |  |  |  |
| Bleeding / Clotting disorder……………….. | Y N | Stroke……………..……………………...…………… | Y N |
|  |  |  |  |
| Asthma……………..……………..…..…………….. | Y N | Spinal injury……………..…………….…………… | Y N |
|  |  |  |  |
| Kidney disease……………..…………………….. | Y N | Neurological disorder..…...…..…..…………… | Y N |
|  |  |  |  |
| Liver disease………………………..…………….. | Y N | Anaesthetic problem in past…………………. | Y N |
|  |  |  |  |
| Joint replacement……………………………….. | Y N | Drug or IV contrast allergy…..….……………. | Y N |
|  |  |  |  |
| Radiation or chemotherapy.….…………….. | Y N | Have you ever smoked?.................…………… | Y N |
|  |  |  |  |
| HIV or hepatitis………………………………….. | Y N | Blood thinning medication…………………… | Y N |

Current medications: …………………………………………………………………………...………………………………………………………………………………

…………………………………………………………………………………………… Allergies: ...………….…………………………………………………………………

Previous surgery: ..………….………………………………………………………………………………………………………...…………………………………………

**I acknowledge that this is an accurate medical history. I understand that this information will be treated with confidentiality and only shared with other health professionals involved in my care.**

**Signature**: ……………………………………………………………………………………………… Date: …..………………………...…………………………………