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| **Patient Questionnaire** | Date: |  |

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| ***Personal Information*** | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: |  | | | | Full Name: | | | |  | | | | | | | | | | | | | | | |
| Sex: |  | | | | Date of Birth: | | | | |  | | | Country of Birth: | | | | |  | | | | | | |
| Occupation: | | |  | | | | | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | | | | | |
| Suburb: | |  | | | | | | | | | | | | | | | | | | Postal Code: | | |  | |
| Telephone: (M) | | | |  | | | | | | | (H) |  | | | | | | | (W) | |  | | | |
| E-mail Address: | | | | |  | | | | | | | | | | | | | | | | | | | |
| Medicare Number: | | | | | |  | | | | | | | | | Ref: |  | | | | | | Expiry: | |  |
|  | | | | | | | | | | | | | | | *(this is the number next to your name)* | | | | | | | | | |
| *Please fill out the following where applicable* | | | | | | | | | | | | | | | | | | | | | | | | |
| Private Health Fund: | | | | | | | |  | | | | | | Member Number: | | | | | | |  | | | |
| Pension Number: | | | | | |  | | | | | | | | | | | Expiry: | | | |  | | | |
| DVA Card Number: | | | | | | |  | | | | | | | | | | Colour: | | | |  | | | |

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| ***Medical History*** | | | | | | | | | | |
| ☑ | | *Tick active problems* | |  | 🗵 | *Cross past problems* | | | | |
| □ | Heart disease | | □ | Asthma | | | □ | Anaemia | □ | Heartburn |
| □ | High blood pressure | | □ | Emphysema | | | □ | Blood transfusions | □ | Stomach ulcers |
| □ | High cholesterol | | □ | Pneumonia | | | □ | Blood clots | □ | Hepatitis |
| □ | Diabetes | | □ | Tuberculosis | | | □ | Stroke | □ | Mental illness |
| □ | Irregular heart rhythm | | □ | Cancer | | | □ | Bleeding disorders | □ | Depression |
| □ | Thyroid disease | | □ | Hearing impairment | | | □ | Visual impairment | □ | Gout |

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| --- | --- | --- | --- | --- |
| Other medical conditions: | | |  | |
| Allergies: |  | | | |
| Previous surgery: | |  | | |
| Family history of medical conditions: | | | |  |

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| --- | --- | --- | --- |
| ***Medications*** – *Please list your current medications below* | | | |
| *Name* | *Dose* | *Name* | *Dose* |
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