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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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