**Patient Questionnaire** Date: .....

***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: .....

***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 |

Other medical conditions: .....

Allergies: .....

Previous surgery: .....

Family history of medical conditions: .....

***Medications*** *– Please list your current medications below*

| *Name* | *Dose* | *Name* | *Dose* |
|---|---|---|---|
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