CONFIDENTIAL PATIENT HISTORY FORM

Welcome to our practice. For our confidential records and to assist in determining your treatment, please answer the following questions as accurately as possible.

Fees are the responsibility of the patient, parent or guardian. Consultations and surgical procedures in the rooms are required to be paid at the time of your visit.

Title: ___________ Given Name: ______________________ Surname: _____________________________

Date of Birth: _______________________ Age: _________________

Home Address: ____ Suburb: ______________________

Ph: __________________ Mob: ____________________ Email: _________________________________

Person reponsible for account: ____

Address: ____ Phone: __________________________

Emergency Contact: _______________________________ Relationship to patient: _____________________

Address: ____ Phone: __________________________

Medicare Number: _________________________ Reference number on card: ________

Name of Private Health Insurance: ________________________________ Member No. __________________

Please specify level of cover: Ancillary ________________________ Hospital __________________________

Period of membership (please circle): Less than 12 months More than 12 months

Department of Veteran Affairs card number: __________________________ Card Colour: ________________

Are you eligible for (please circle): TAC / WORKCOVER
Please specify: Claim No. _______________ Company _______________ Case Worker _________________

Medical GP / Clinic: ____
Address: ____

Dentist / Clinic: ____
Address: ____

If the patient in under 18 years of age, please specify:

Mother / Guardian: ___________________________ Father / Guardian: _____________________________

DISCLOSURE AUTHORISATION

We respect your privacy and will not disclose any information to anyone without your prior approval unless it is clinicians and hospitals directly involved with your treatment / care.

I _____________________________________ give authorisation for disclosure of my records or treatment with the following next of kin(s):
1. ____ relationship: _______________________
2. ____ relationship: _______________________

Signature: _________________________________ Date: ___________________________

MEDICAL HISTORY QUESTIONNAIRE

Weight (kg): ________ Height (cm): ________ Surgeon to complete: BMI ________ ASA ________

Have you ever had any **heart** related problems? Y N

If yes, please specify: ____

Have you ever had any **breathing / lung** related problems such as asthma,
bronchitis, emphysema, bronchiectasis, sleep apnoea? (Please circle) Y N

Are you a **smoker?** If yes, how many per day? _________________ Y N

Do you have any **bleeding or clotting** disorders? Y N

Have you ever had prolonged **bleeding** from dental procedures? Y N

Do you take any blood thinners: Y N

(Please circle) Warfarin, Clopidogrel, Xarelto, Pradaxa, Clopidogrel, Aspirin, Other ___________

Do you get **acid reflux** into your mouth or have you had **stomach ulcers**? Y N

Do you regularly experience **anxiety**? Y N

Have you ever had a **gag** reflex? Y N

Do you have **diabetes?** Y N

If yes, do you take insulin? Y N

Blood Pressure (please circle) NORMAL / HIGH / LOW

Do you take medication for **osteoporosis** or take Fosamax, Zometa or Prolia Y N

Do you have any joint replacements & if yes, year inserted (hip, knee, shoulder)? Y N

Have you ever been exposed to an infectious disease? Y N

If yes, please circle: Hepatitis B or C, HIV, rheumatic fever, scarlet fever

Have you ever had a problem with any type of **anaesthetic?** Y N

If yes, please specify: ____

Are you **pregnant** or **breast feeding**? (Please circle)

Do you have any allergies (medication, latex, food) Y N

If yes, please specify: ____

Please list any regular medications incl. aspirin, contraceptives, herbal, vitamins

____

Do you have any other medical conditions not specified above?

If yes, please specify: ____

Rarely, ambulance transfer to a nearby hospital may be required (eg. for anaphylaxis).

Do you have ambulance cover? Y N

If no, do you accept the associated ambulance costs in the unlikely event it is required? Y N

Office: If sedation required, please forward a copy to the anaesthetist at least 24 hrs prior.