Please provide the following details to facilitate your consultation. All information provided will be handled in the strictest confidence with due professional care in accordance with the practice Privacy Policy. A copy of this policy document is available upon request. By providing us with your email address or mobile phone number you agree to the receipt of emails or SMS of an administrative nature only. No clinical details will be transmitted through this unencrypted route. For accurate record keeping, audio recording may be in use during your consultation. Thank you

Given Names:		Surname:	
Address:			
		Date of Birth:	
Post Code:		Height:	Weight:
Telephone - Home:	Mobile:		Work:
Email:			
Occupation:	Marital Status:	No. of Children:	Ages:
Next of kin - Name	Relationship:	Contact No:	
Referring Doctor:	Usual GP:		
Name of Health Insurance Fund:			
Membership Number:	Hospital Cover: ☐ Yes ☐ No		
Medicare number:	# Next to name:	Valid to date:	

Are there any other doctors involved in your healthcare whom you wish to be kept informed of your consultations and treatments? (Please list):_____

_____

Please list any previous operations with approximate dates:

_____

_____

_____

_____

Please list any other hospital admissions with approximate dates it not covered above:

_____

_____

_____

Have you had, or are you currently receiving, any other medical treatment:

_____

_____

_____

Please list any current medications, drugs, inhalers or treatments being received:

_____

_____

_____

_____

Please list any drugs or medications you are allergic to:

_____

_____

_____

Do any diseases or conditions seem to run in the family?

_____

_____

_____

Do you currently smoke: _____ Number per day: _____

Have you ever been a smoker: _____ When did you cease: _____