

Patient Details

The information required on this form is a mandatory requirement by the Health Department but will be regarded as Confidential.

Mr/ Mrs/ Ms/ Miss/ Master/ Dr Surname: _____	
Given Name: _____ Middle Name: _____	
Preferred Name: _____ Indigenous/ Torres Strait Islander/ Other _____	
DOB: ___/___/_____ Email Address: _____	
Street Address: _____ Suburb: _____ P/C: _____	
Postal Address: _____ Suburb: _____ P/C: _____	
Home Phone: _____ Work: _____ Mobile: _____	
Occupation: _____ Family Dr: _____	
Country of Birth: _____ Marital Status: _____	
Next of Kin: _____ Relationship: _____ Contact Number: _____	
Medicare Number: _____ Position: _____ Expiry: _____	
Uninsured or Private Health Insurance Company: _____ Number: _____	
Position on card: _____ Excess Amount: _____ Member Since: _____	
DVA Gold or DVA White: _____ File Number: _____	
<i>Only fill out if payer details are different to information listed above</i>	
Account Payer: Self /Parent /Guardian /Employer /Insurer /Other _____	
Name: _____ Contact Number: _____ DOB: ___/___/_____	
Address: _____ Claim Number: _____	
Medicare Number: _____ Position: _____ Expiry: _____	
<i>(If Parent or Guardian)</i>	
Have you worked or been IN HOSPITAL in the last 12 months	
1. <input type="checkbox"/> No	* If yes to Question 3 or 4, please advise staff.
2. <input type="checkbox"/> Yes – in Western Australia	
3. <input type="checkbox"/> Yes – in Another State	
4. <input type="checkbox"/> Yes – Overseas	

Previous Medical History

MR 1

PLEASE COMPLETE THE FOLLOWING IMPORTANT INFORMATION

<p>Surname:</p> <p>Given Name:</p> <p>DOB:</p> <p>CURRENT AND PRIOR ILLNESSES</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>PREVIOUS OPERATIONS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>CURRENT MEDICATIONS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>ALLERGIES</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>INCREASED RISK</u></p> <p>The following conditions increase the risk of surgery and special precautions may be required. Please tick the boxes and advise if any of the following are present when booking the procedure.</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>HEART ATTACK or ANGINA within the last 6 months.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>STROKE within the last 6 months.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>SEVERE RESPIRATORY DISEASE such as severe asthma, chronic bronchitis, emphysema or sleep apnoea.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>BLEEDING DISORDER such as Hemophilia, von Willebrands Disease or 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