**New Patient Questionnaire -** please complete and email to [admin@easternurologyperth.com.au](mailto:admin@easternurologyperth.com.au)

**Personal Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | | |
| Date of Birth: | Occupation: | | |
| Address: | | Postcode: | |
| Contact Number: | Email: | | |
| Next of kin: | Next of kin contact: | | |
| Aboriginal / Torres Strait Islander (please circle) | Yes | | No |
| Cultural background: | | | |
| Interpreter required (please circle) | Yes | | No |

**Medicare / Health Fund Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Medicare Number: | Reference No: | | Expiry: |
| Private Health Fund: | | Member No: | |
| DVA Number: | | Card colour: | |

**GP information**

|  |
| --- |
| GP name: |
| Clinic name / address: |

**Medical History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| High blood pressure | Yes | No | Kidney disease | Yes | No |
| Diabetes | Yes | No | Spinal or neurological disorders | Yes | No |
| Bleeding / clotting disorders | Yes | No | Anaesthetic problems in past | Yes | No |
| Lung of breathing disorders | Yes | No | Radiation or chemotherapy | Yes | No |
| Heart disease | Yes | No | Current or ex-smoker | Yes | No |
| Liver disease | Yes | No | HIV or hepatitis | Yes | No |
| Anxiety / depression or other mental health conditions | Yes | No | Gastritis or stomach ulcers | Yes | No |
| Previous surgeries: | | | | | |
| Allergies: | | | | | |

I can confirm that the above information and medical history is accurate to the best of my knowledge. I understand that this information is confidential and will only be shared with other health professionals involved in my care.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_