**New Patient Questionnaire -** please complete and email to 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_