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: _____