MR STEWART SKINNER, MBBS, PhD, FRACS
General Surgeon

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PLEASE COMPLETE DETAILS IN BLOCK LETTERS

FULL NAME: Mr Mrs/Ms/Miss……..... *(please circle)*

DATE OF BIRTH ……AGE…….....

ADDRESS: …….....

……POSTCODE…….....

TELEPHONE NOS: Mobile…….....

Email:…….....

PRIVATE HOSPITAL FUND…….....
Membership No. ……..

Medicare No……Number next to name.……

GENERAL PRACTITIONER…….....

REFERRING DOCTOR…….....
(if different from general practitioner)

OCCUPATION…….....

NEXT OF KIN - NAME …….....

RELATIONSHIP:……CONTACT NO:……..…….....

Please ✓ if applicable
History, have you ever had

High blood pressure ☐	Heart problems ☐	Blood clots ☐	Bleeding problems ☐
Diabetes ☐	Stroke ☐	Fits/epilepsy ☐	Chest/lung problems ☐

Medications, do you take

Warfarin ☐ Aspirin ☐ Any blood thinning medication, details…….

Do you smoke ☐ How many per day……..

Your Privacy

In order to provide quality health care, your consent is required to collect personal information about yourself, including personal details and a detailed medical history. The information provided may be disclosed to others involved in your health care, including other doctors or specialists outside this medical practice. This information will only be disclosed for the purposes of your treatment.

Consent to release of medical information – Signed .....

Dated: .....