

COVID-19 QUESTIONNAIRE

Name:

Have you had COVID-19: **YES/NO**

Date you had COVID-19:

Are you fully vaccinated: **YES/NO**

Do you currently have any symptoms: **YES/NO**

Personal Details

Please enter details as they appear on your Medicare card

Surname: _____ Mr/Ms/Mrs/Miss

First Name: _____ Middle Initial: _____

Date of Birth: _____

Address: _____

Postcode: _____ Country of Birth: _____

TELEPHONE: Home: _____ Work: _____

Mobile: _____ Occupation: _____ (optional)

Email: _____ **ALL LETTERS WILL BE EMAILED**

URGENT CONTACT/ NEXT OF KIN: Name: _____

Phone: _____ Relationship: _____

MEDICARE CARD NO. _____

Expiry Date: _____ Reference No: (position on card, e.g. 1,2,3) _____

DO YOU HAVE A DEPARTMENT OF VETERAN'S AFFAIRS GOLD CARD? YES/NO

If yes, DVA Gold Card No. _____

DO YOU HAVE PRIVATE HEALTH INSURANCE TO COVER YOU IN HOSPITAL? YES/NO

If yes, name of health fund: _____

Membership No. _____ Reference No. (position on card) _____

When did you join your fund (approx.)? _____

DO YOU HAVE A HEALTH CARE CARD OR PENSION CARD? YES/NO

Card No. _____ Type of pension (e.g. Age, DSP) _____

NAME OF REFERRING DOCTOR: _____

DATE OF REFERRAL: _____

WHO IS YOUR NORMAL GP? _____

Suite 114, 4 Hyde Parade
Campbelltown NSW 2560

Dr Kathryn Stewart
MB.BS., (Syd), Ph D., FRACS
Specialist Surgeon

Provider No: 046292RL
ABN No: 96 079 182 120

All correspondence:
PO Box 1032
Campbelltown NSW 2560
All enquiries and appointments:
Ph: (02) 4629 0900
Fax: (02) 4628 0735

PATIENT HEALTH QUESTIONNAIRE

Have you now, or ever before, had:

NAME: _____
AGE: _____
DATE: _____

	YES	NO
Kidney problems		
Heart trouble		
Stroke		
Lung disease e.g. asthma		
Diabetes		
Blood pressure problems		
Stomach ulcers		
Liver disease/hepatitis		
Blood disorders or clots in the leg		
Epilepsy		
Rheumatic fever		
Are you in a high risk group of AIDS		
Any problems with anaesthetics: - General - Local		
Any family history of anaesthetic problems		
Blood transfusion		
Could you be pregnant?		
Do you smoke?		
Do you drink alcohol? If yes, how much per week		
Do you have any allergies? If yes, please detail:		
Have you had any serious illnesses? If yes, please detail:		

List medications or substances used:

1. _____
2. _____
3. _____
4. _____

List previous operations:

1. _____
2. _____
3. _____
4. _____

**PLEASE READ PRIVACY INFORMATION
AND SIGN OVERLEAF**

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PRIVACY INFORMATION AND CONSENT FORM

The law gives you certain rights in relation to information that you give to this medical practice. We need your consent to collect personal information about you. The fact that you have come here implies that you consent to us knowing about your health situation either for a particular event or generally. This form explains what your rights are over the use we make of the information and how we may disclose it to other medical service providers.

Please carefully read the following information about privacy issues, then sign this form where indicated below. It will go on your file and you may examine it at any time.

The main reason we collect information from you is so we can assess, diagnose and treat your illness properly. We will also use the information you provide in the following ways:

- Administration of this practice.
- Billing, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including doctors and specialists outside this practice who may become involved in treating you. This may occur through referral to other doctors, or for medical tests, and in the reports or results returned to us following the referrals.
- Disclosure to others for medical defence purposes if necessary.

PATIENT'S ACKNOWLEDGEMENT

I have read this form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.

I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not at first understand.

Signed: (patient) _____

Date: _____

Name: (please print) _____

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Date: _____

I _____ DOB: _____ give permission for my images to be uploaded on Dr Kathryn Stewart Instagram site. Pictures are in no way named or identified. This site is for the purpose of teaching both students, doctors and patients.

Signature: _____

Print Name: _____

Macarthur Specialist Breast Health Clinic

Dr Kathryn Stewart
MB.BS., (Syd), PhD FRACS
Specialist Surgeon
114/4 Hyde Parade
Campbelltown NSW 2560

Today's Date: _____

Name: _____

Age: _____

Breast Symptoms: _____

Have you had a recent:

Mammogram: Y/N (please circle) Date: _____

Ultrasound: Y/N (please circle) Date: _____

Biopsy: Y/N (please circle) Date: _____

Background:

Age at first period: _____ Age at first pregnancy: _____ How many children: _____

Breastfeeding: Y / N (please circle) Duration: _____

Oral contraceptive pill: Y / N (please circle) Duration: _____

Hormone replacement therapy: Y / N (please circle) Duration: _____

Natural hormone therapies: Y / N (please circle) Duration: _____

Fertility treatment: Y / N (please circle) Duration: _____

Have you gone through menopause?

Past Breast Health:

Previous breast biopsy: Y / N (please circle) Date: _____

Result: _____

Other breast history: _____

Family History:

Breast cancer: Details _____

Ovarian cancer: Details _____

Prostate cancer: Details _____

ULTRASOUND SCANS AT THIS PRACTICE

As part of your consultation, the doctor may perform an ultrasound examination. We have provided some information here about what to expect when you have an ultrasound. Feel free to discuss any questions or concerns you may have with the doctor.

HOW DO I PREPARE FOR AN ULTRASOUND? There is no preparation for an ultrasound. Please give any previous films or scans you have to the Receptionist.

WHAT IS AN ULTRASOUND SCAN? An ultrasound scan uses high frequency sound waves to create pictures of soft tissues and organs inside the body. The non-audible sound passing into your body is safe because it doesn't use radiation. Ultrasound equipment uses a hand held scanner (transducer) which the doctor places against your skin and moves around the area for imaging. The transducer emits sound and detects the returning echoes from the target area. This information is converted to a moving image displayed on a screen. The ability to see a moving image makes ultrasound a good tool for guiding procedures such as needle biopsies and injections.

WHAT HAPPENS DURING AN ULTRASOUND SCAN? You will be asked to sit or lie down with the area to be scanned exposed. The doctor puts a saline based gel on the area of your body to be scanned to ensure the transducer makes good contact with the surface of the body. The transducer is then held against the area for imaging and moved around to give different views. This is generally not painful, although some pressure may need to be applied to improve visualisation. The doctor watches the ultrasound image on a monitor as they move the transducer around and still images can be recorded.

ARE THERE ANY AFTER-EFFECTS FROM ANY ULTRASOUNDS SCAN? Ultrasound is safe and harmless. It is possible to go about your normal activities straight after scans, but this may not apply if your scan has been accompanied by an injection. If an injection is part of your study you will be advised of any precautions and in some cases you may be advised not to drive, do any heavy lifting/work for several hours after an injection.

WHAT ARE THE RISKS OF AN ULTRASOUND SCAN? An ultrasound scan does not have any known risks, side effects or complications and is considered to be very safe.

WILL I BE INFORMED OF ANY RESULTS? Any findings from the ultrasound will be discussed with you at the time of your consultation. Your referring doctor will also be informed of any findings and a copy of any still images taken will be placed on your medical record.

PATIENT CONSENT

The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor.

I consent to undergo the procedure/s or treatment/s as documented on this form.

Patient Name: _____ (please print)

Signature: _____

Date: _____