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**

MACARTHUR SPECIALIST AND PROFESSIONAL CONSULTING SUITES

Suite 114, 4 Hyde Parade
Campbelltown NSW 2560

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? _____

Dr Kathryn Stewart

MB.BS., (Syd), Ph D., FRACS

Specialist Surgeon

Suite 114, 4 Hyde Parade
Campbelltown NSW 2560

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

NAME: _____

AGE: _____

DATE: _____

Have you now, or ever before, had:

	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: _____