Personal Details and important information.

First Name ..... **Birth Date** (dd / mm / yyyy) .....

Last name: .....

Number & Street Address: .....

Suburb / Town: ..... **Postcode** .....

Mobile Phone: .....

Alternate Contact Ph. (optional) ..... **Name** .....

Email Address: .....

Preferred contact method: .....
(instructions in case we need to contact you urgently. Best time of day & method,)

Your regular doctor .....

Doctor's Practice & Address .....
(if no regular doctor, please write the details of the doctor who you will see for a check-up if required)

Medicare Number ..... Ref ..... Expiry .....

Allergies .....

Medical problems .....

Have you been to The Private Clinic previously? **YES / NO**

Do you or your carer require a medical certificate? **YES / NO** .....
(carer's name if required)

How did you hear about The Private Clinic? (Circle one)
(1) Doctor's referral (2) Google search (3) Friend (4) Previous visit (5) Other .....

Support person with you today: ..... **Mobile:** .....
(nurses will call this person about 30 minutes before discharge)

In an emergency please contact: ..... **Mobile:** .....
Does this person know that you are at the clinic today? YES / NO

Please tick

- ☐ **VALUABLES:** The Private Clinic takes no responsibility whatsoever for valuables or other possessions. We will provide you with a locker for your clothing but please make arrangements for the safe storage of any valuable possessions.
- ☐ **PRIVACY STATEMENT**: Staff at the Private Clinic are required to collect information regarding your health to provide a service to you. Once collected, this information and relevant test results may be sent to your referring doctor, doctor of your choice or other external healthcare facility where follow-up treatment is necessary. The Private Clinic will not disclose your personal information to any other person without your consent. Our detailed privacy policy is available on our website (www.privateclinic.com.au) or on request from our reception desk.
- ☐ **YOUR AUTHORITY TO US:** In some circumstances it may be necessary for the Private Clinic to exchange information with other health care providers during or after your visit. This may include pathology services, Medicare, your GP, diagnostic imaging services, or any other external healthcare facilities including hospitals or specialist services. We may need to contact you after your treatment. By completing and signing this document you authorise us to collect, maintain, use and disclose your personal information in the manner set out in our privacy statement. You also agree to us contacting you by telephone, email or SMS (text message) if required.
- ☐ **IMPORTANT NOTE ON CLINICAL TESTS:** To provide an optimal and safe service, we may send pathology samples to an external pathology provider to diagnose certain conditions which may affect your treatment. If you have a Medicare card, Medicare covers these costs. We will contact you if the result from any test is abnormal. For non-Medicare patients, we will advise you if pathology testing is required to diagnose certain conditions which effect your treatment and you will receive an invoice from the pathology company which you must pay. If you have private insurance, these costs may be claimable.
- ☐ **COSTS:** Procedure fees are advised before every appointment based on the information that was provided to us. We reserve the right to amend the fee where our preliminary examination shows that a pregnancy is second trimester. All fees must be paid prior in full prior to treatment commencing.
- ☐ **ADDITIONAL FEES:** Please be aware that should you require external pathology, diagnostic imaging, or referral to a facility other than the Private Clinic, the fees are determined by that provider and will be invoiced directly to you. We have no discretion over these fees and you will be responsible for payment.

I have read and understood the privacy statement and authority to collect information.

Signed ..... Date ……

PLEASE CIRCLE YES OR NO EG. (YES / NO)

MEDICAL HISTORY	
Have you ever had any of the following conditions?	
Heart murmur	(YES / NO)
Any heart or lung problem	(YES / NO)
High blood pressure	(YES / NO)
Low blood pressure	(YES / NO)
Asthma	(YES / NO)
If yes, when did you last take anything for it?	
Epilepsy	(YES / NO)
Diabetes	(YES / NO)
If yes, is it treated with diet only oral medication insulin injection	 (YES / NO) (YES / NO) (YES / NO)
Bleeding tendencies	(YES / NO)
Blood clots / DVT / Thrombosis	(YES / NO)
HIV	(YES / NO)
Hepatitis A	(YES / NO)
Hepatitis B	(YES / NO)
Hepatitis C	(YES / NO)
Have you been treated for any other medical condition?	(YES / NO)
Please provide details.	
What is your blood group? (if known)	
Are you currently breast feeding?	(YES / NO)
Do you have any dentures or oral piercings?	(YES / NO)
MEDICATIONS	
Do you take medication?	(YES / NO)
If yes, what is it called?	
For what condition is this medication taken?	
How often do you take it?	
When was it last taken?	
ALLERGIES	
Do you have any allergies? *e.g. penicillin, antibiotics, aspirin, soy products, egg, latex, plasters (Band-Aids), antiseptics or anything else?*	(YES / NO)
Please provide details	
DO YOU SMOKE?	(YES / NO)
If yes, how many cigarettes per day?	
On average, how many alcoholic drinks per week?	
Do you use recreational drugs?	(YES / NO)
Have you ever used IV drugs?	(YES / NO)
PREVIOUS SEDATION / GENERAL ANAESTHETIC	
Have you ever had an anaesthetic where you were sedated or fully asleep?	(YES / NO)
What was the operation / procedure for?	
Have you, or a blood relative, ever had any problems with an anaesthetic?	(YES / NO)
If yes, please provide details.	
FASTING	
When did you last eat any food or drink anything other than water?	
When did you last drink water?	
MENSTRUAL HISTORY	
How often do you get a period? (less than 28 days, approx. 28 days, more than 28, or irregular?)	(<28 / 28 / >28 / IRREGULAR)
How many days do you usually bleed?	
How would you describe your normal amount of bleeding?	(LIGHT / MODERATE / HEAVY)
How would you describe the level of pain that you normally experience during a period?	(NONE / MILD / MODERATE / SEVERE)
GYNAECOLOGICAL TREATMENT	
Have you ever had any treatment to your cervix, including Cone Biopsy, Lletz procedure, Laser or Diathermy, or any other gynaecological surgery?	(YES / NO)
If yes, please provide details:	
Have you ever had an ectopic pregnancy (in the fallopian tube)?	(YES / NO)
If YES, what happened?	

If you are unsure of any of these questions, please ask the doctor during your consultation.

To the best of my knowledge, the answers to the above questions are correct.

Signed:.....