

Welcome to The Private Clinic.

Please complete as much information as possible on both sides of this sheet.

Last name:

First name:

Date of birth: / /

Allergies:

Medical problems:

.....

Medicare number:

Ref. No. Valid To \

Address :

.....

Suburb / town:

State: Postcode:

Home phone:

Mobile:

Did a GP recommend us to you? ☐ Yes ☐ No (if yes, please complete the following)

As a courtesy to referring GPs, we send a letter summarising your treatment and aftercare. If you plan to see a different GP for your follow-up, please nominate that doctor below.

Doctor's name:

Practice name & address:

.....

Contact in case of an emergency: Phone:

Name of person who will be collecting you from the clinic afterwards.

(optional) Phone:
(Our nurses will call this person about 30 mins prior to your discharge)

You must not drive a car or operate machinery for the rest of the day after having an anaesthetic.

How did you hear about The Private Clinic?

☐ Referring doctor ☐ Friend ☐ Yellow Pages ☐ Internet search ☐ Previous visit

Please complete the information on the other side of this sheet and return to the receptionist along with your Medicare card and any other relevant information (eg. a doctor's letter or ultrasound report if you have them)

PLEASE CIRCLE YES OR NO

EG. (YES / NO)

Name:

Date:

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)

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?

(YES / NO)

e.g. penicillin, antibiotics, aspirin, soy products, egg, latex, plasters (bandaids), antiseptics or anything else?

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?

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: