



New Patient Questionnaire - Welcome to our practice
Patient or guardian to complete

Today's Date _____

Your Details

Surname	First Name	Gender	DOB

Residential Address	Suburb	Postcode

Occupation / How you spend your time

Home Phone	Work Phone	Mobile Phone

Email

Are you happy to receive our email blog? No spam - we promise! - Y / N

Health Fund Details

Health Fund	Membership Number

Inpatient Private Hospital Cover - Y / N

Medicare Number	Ref Number	Expiry Date

DVA Number	Card Color	Expiry Date

Aged Pension Number	Expiry Date



Your GPs Details

GPs Name	Practice	Suburb

Referring Doctors Details (if different to above)

Doctors Name	Practice	Provider Number

Next of Kin

Name	Relationship

Address (if different to your own)	Suburb	Postcode

Contact Number

Help Us To Help You

How did you hear about Perth Urology Clinic? We are interested to know!

GP	Word of Mouth
Web Search (Google)	Social Media (Facebook, Twitter)
Other	

Is there anything that you would like to tell us that may help us improve our patient care?

(If you don't feel comfortable writing it down, please mention your concerns to your doctor or one of our staff)



Privacy Policy

Perth Urology Clinic maintains a strict privacy policy with respect to collection, storage, handling and distribution of your personal information. If you wish to view the policy, please ask our receptionist for a copy. This practice abides by the requirements of the *Privacy (Private Sector) Amendment Act 2000*

If you do not want to view the full policy, please sign and date below

Name _____
Signature _____
Date _____

Thanks,
and welcome to Perth Urology Clinic



Health Questionnaire

Do you *or have you ever* had:

Diabetes	Y / N
High Blood Pressure	Y / N
Heart Problems	Y / N
Breathing Problems	Y / N
Kidney Problems	Y / N
Thyroid Disease	Y / N
Stroke or Similar Problems	Y / N
Epilepsy, Seizure or Fits	Y / N
Parkinsons Disease or Multiple Sclerosis	Y / N
Spinal Problems	Y / N
Tendency to Bleed	Y / N
Tendency to Clot (Deep Vein Thrombosis, PE)	Y / N
Depression or other psychiatric illness	Y / N
Chemotherapy or Radiation Therapy	Y / N
HIV or Hepatitis	Y / N
Problems with Anaesthetics	Y / N

Any other medical problems? _____

What previous surgery have you had? (please list)

Please List all allergies (including food allergies)

What medications do you take (including vitamins and supplements)?
Please note the dose and time that you take them.
Please note if on any blood thinners (warfarin, clopidogrel, aspirin)
