Randwick Urology

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PERSONAL DETAILS

TITLE _______ SURNAME ____________________ GIVEN NAMES ________________________________

DATE OF BIRTH ___YYYY___ / __MM__ / __DD__

ADDRESS ____

____ POSTAL CODE __________

TELEPHONE (H) __________________________ MEDICARE NO ____________________________

TELEPHONE (W) __________________________ NO. ON CARD ____________________________

TELEPHONE (M) __________________________ EXPIRY DATE ____________________________

PENSION BENEFIT NO. (AGED PENSION) IF APPLICABLE _____________________________________

VETERAN AFFAIRS NO. (IF APPLICABLE) ____

MEDICAL INSURANCE DETAILS

DO YOU HAVE PRIVATE HEALTH INSURANCE FOR ADMISSION TO HOSPITAL? YES / NO

NAME OF HEALTH FUND: __________________________ MEMBERSHIP NO: ___________________________

REFERRAL DETAILS

REFERRING DOCTOR ____

NAME OF USUAL GP (IF DIFFERENT FROM ABOVE)____

GENERAL HEALTH DETAILS

PLEASE LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE CURRENTLY BEING TREATED: ________

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WHAT MEDICATIONS ARE YOU TAKING ON A REGULAR BASIS? PLEASE INCLUDE OVER THE COUNTER DRUGS, SUCH AS ASPIRIN AND VITAMINS ____

____

PLEASE LIST ANY ALLERGIES YOU MAY HAVE: ____

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WHICH PREVIOUS SURGICAL PROCEDURES OR OPERATIONS HAVE YOU HAD? _______________________

____

DO YOU SMOKE? YES / NO IF SO, HOW MANY CIGARETTES PER DAY? ________________

DO YOU DRINK ALCOHOL ? YES / NO IF SO, IN WHAT QUANTITY? __________________

PLEASE WRITE , IN YOUR OWN WORDS, YOUR REASONS FOR SEEING THE DOCTOR TODAY ___________

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SIGNATURE ___________________________________ TODAY'S DATE ___YYYY___ / __MM__ / __DD__