PATIENT HISTORY

**Please complete both sides and return it to Receptionist*

First Name: _____Last Name: _____

Residential Address: _____

Suburb:_____State: _____Postcode:_____

Email: _____

Phone Number: _____ Mobile Number: _____

Date of Birth: _____ Age: _____ Medicare number: _____ Exp._____

DVA Number _____ Pension/Health/Student Number _____

Private Health Fund _____ Number_____

Occupation: (current/previous): _____

Marital Status: _____ Number Children: _____Hobbies: _____

Emergency Contact Name: _____ Phone No.: _____

Name and Address of your GP: _____

_____

Name and Address of other practitioners involved with your care that require a copy of your correspondence:

_____

Q1. Do you smoke? Yes / No **Q2. Have you ever smoked?** Yes / No

If Yes, maximum smoked per day: _____ Year started: _____ Year stopped: _____

Q3. Passive smoke exposure: Light / Heavy

Q4. Alcohol Consumption (average per day- standard drinks): _____

Q5. Current Medications (Please list all details):

Medication and Dose:	*Reason:*	*Year Commenced:*

Q5b. List any illnesses or operations you have had:

Illness:	*Year Commenced:*

Q6. Please list any drug allergies / reactions to anaesthetics that you have had:

Drug:	*Type of Reaction:*

Q7. Have you received the following vaccinations? If so, when?

Flu Vaccine: _____ Pneumovax: _____ BCG Vaccine (for Tuberculosis: _____

Q8. Has there been any past exposure to:

TB (Tuberculosis) / Asbestos: Yes / No Other noxious fumes and dusts (for prolonged periods) Yes / No

Q9. Is there any major health related illness in your family? (e.g. Communicable disease, Heart disease, Diabetes, Cancer, Sleep Apnoea or heavy snoring). If so, please list below.

_____

Signed: _____ Date: _____