

Clinical Information Form-Confidential (PLEASE COMPLETE BOTH PAGES)

Surname: First: Title: Dr Mr Mrs Ms
 Address:(Home):
(Work):
Postcode.....(Mob):
 Date of Birth:..... Age:yrs Height: Weight:kg
 Medicare No:Exp: Vet. Affairs No:
 Health Fund: Membership No:
 Occupation:

Worker's Comp/Third Party Claim No:
 Case Manager: Insurance Co:
 Postal Address:
 Postcode.....

Referring Doctor:Provider No:
 Address: Date of referral:
Postcode.....Tel No:
 GP:Tel No:
 Address:Postcode.....
 Reason for referral:

Next of Kin / Parents

Contact 1	Relationship	Number
Contact 2	Relationship	Number

Do you smoke? Yes/No How much?
 Do you drink alcohol? Yes/No How much?

Are you taking Aspirin, eg Cardiprin, Dispirin? Yes/No
 Are you taking Blood Thinners eg Warfarin, Asasantin,
 Dipyridamole Ticlopidine, Plavix Yes/No

Do you suffer from (PLEASE TICK THE BOXES)

Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	Others
	<input type="checkbox"/> Angina	<input type="checkbox"/> Heart Attacks	
	<input type="checkbox"/> Abnormal Heart Beat	<input type="checkbox"/> Heart Failure	
Lung Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	Others
	<input type="checkbox"/> Chest Infections	<input type="checkbox"/> Blood Clots in the Lung	
	<input type="checkbox"/> Emphysema		
Gastric Problems	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Hepatitis	Others
	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Liver Failure	
Kidney Disease	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Kidney Infections	Others
	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Kidney Failure	
Neuro Problems	<input type="checkbox"/> Strokes	<input type="checkbox"/> Dizziness	Others
	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Foot drop	
Hormonal Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	Others
	<input type="checkbox"/> Osteoporosis		
Malignancy	<input type="checkbox"/> Brain Tumour	<input type="checkbox"/> Lung Cancer	Others
	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Prostate Cancer	
	<input type="checkbox"/> Bowel Cancer	<input type="checkbox"/> Skin cancer	

Previous Operations	Year	Previous Operations	Year

Current Medications	Dose	Times per day

Drug Allergy	Type of Reactions

Thank you for completing this information sheet