PATIENT REGISTRATION & MEDICAL HISTORY FORM

Patient Details:					
Name					
Address					
Date of Birth		Home Phone No.:			
Mobile Phone No.:		Work Phone No:			
Height:		Weight:			
Pension/Healthcare Card Number		Expiry Date			
DVA Number		DVA Card Colour			
Medicare Number		Expiry Date		Ref. Number	
Name of Private Health Fund		Membership Number			
GP Details					
Name					
Address					
Telephone Number		Fax Number			
Emergency Contact Details:					
Name					
Home Phone Number		Mobile Phone Number			
Relationship to patient					
Are you currently seeing any other Specialists? Yes / No (If yes, please list below)					
Name:					
Clinic:					
Speciality:					
Phone:					
Fax:					
Address:					

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List of current and past medical problems:			
List of current Medication(s):			
Family History:			
Are there any hereditary health diseases? Yes / No (please circle)			
If yes, please name them:			
Do you have diabetes? Yes / No (please circle)			
Diet Controlled / Tablets / Insulin ? (please circle)			
Do you have any allergies? Yes / No (please circle)			
If yes, please name them:			
Are you a smoker? Yes / No (please circle)			
How long have you been smoking?		How many cigarettes do you smoke per day?	
How many standard alcoholic drinks do you consume per week?			