# DR MELINDA PASCOE
## Patient Questionnaire

Surname: ______________________ Given Names: ______________________ Preferred Name: ______________ (Only enter if you have a preferred name)

Date of Birth: ____/____/19____ Title: (Circle) MR | MRS | MISS | MS | MAST | DR | Height: ________ cm Weight: ________ kg

Address:

**[CONTACT DETAILS]**

Home No: ______________________ Work No: ______________________ Fax No: ______________________

Mobile No: / State: ______________________ Email Address / Postcode: ______________________

**[NEXT OF KIN DETAILS]**

Next of Kin Name: ______________________ Contact Number: ______________________

**[MEDICARE DETAILS]**

Medicare Number: ______________________ **Expires:** ______________ **Reference:** ______________
** 10 numbers **this is number next to your name**

**Hospital Fund:** **YES / NO**

Pension Type ______________ # Expiry ______________

DVA Number: ______________________ Expires: ______________ Gold / White: ______________

**[REFERRING DOCTOR DETAILS]**

Referring Doctor: ______________________ Local Doctor: ______________________

Copy of report to: If yes, list name & address: ______________________

Dr Melinda Pascoe complies with the Commonwealth Privacy Act in relation to the management of your personal information. We will take every measure to ensure that your confidentiality is respected and your information is stored securely and appropriately. We only collect details that are necessary to the provision of your health care. Our staff will always endeavour to be sensitive to your needs when obtaining personal health information. However, we are also committed to act in your best interest by obtaining a thorough assessment of your condition and medical history. Your health data will only be shared with other health professionals who are involved in your care and who you have authorised to access your information. You also have a right to access your personal health information at any time.

I consent to Dr Melinda Pascoe collecting and using my health information. I also consent to my health providers accessing my health information relevant to any of my health needs. I have read the Practice Policy and agree to abide by this.

**PRACTICE POLICY**
It is the policy of this practice NOT to offer advice to any patient except in consultation. No advice will be given by telephone or email. If you have an urgent concern please present to your nearest Accident & Emergency Department or to your general practitioner.

Print Full Name: ______________________ Date: ______________ Signature: ______________________

# Medical History Questionnaire

**Given name:** ______________________ **Surname:** ______________________ **DOB:** ________________

| Questions: (Please tick Yes or No) | Yes | No |
|---|---|---|
| **Do you have ANY metal in your body? If yes, please explain:** | ☐ | ☐ |
| | | |
| **Have you EVER had any heart surgery? If yes, please explain:** | ☐ | ☐ |
| | | |
| **Have you had any RECENT surgery? If yes, please explain:** | ☐ | ☐ |
| | | |
| **Do you have any allergies?** | ☐ | ☐ |
| List: | | |
| **List any medications you currently take?** | ☐ | ☐ |
| | | |
| **Do you have any significant medical history?** | ☐ | ☐ |
| If yes, what: | | |
| **Do you have any significant family history?** | ☐ | ☐ |
| If yes, what: | | |
| **Have you ever had episodes of weakness or numbness?** | ☐ | ☐ |
| If so, what and where: | | |
| **Have you ever had the sensation of burning or coldness of your hands or feet?** | ☐ | ☐ |
| If so, what and where: | | |
| **Do you have episodes of slurring of speech?** | ☐ | ☐ |
| If yes, describe: | | |
| **Have you ever had disturbances or loss of vision in one or both eyes?** | ☐ | ☐ |
| If yes, describe: | | |
| **Have you ever had blackouts, faints or seizures?** | ☐ | ☐ |
| If yes, describe: | | |
| **Do you have frequent headaches?** | ☐ | ☐ |
| If yes, describe: | | |

| Questions: (Please tick Yes or No) | Yes | No |
|---|---|---|
| **Have you ever had episodes of dizziness or spinning head when moving?** | ☐ | ☐ |

# Medical History Questionnaire

Given name: ______________ Surname: ______________ DOB: __________

If yes, describe:

**Have you ever had a heart attack?** ☐ ☐

If yes, when:

**Have you ever had a stroke or TIA?** ☐ ☐

If yes, when:

**Have you ever had palpitations, chest discomfort or tightness?** ☐ ☐

If yes, describe:

**Do you feel dizzy or faint when you stand up?** ☐ ☐
**Do you take Aspirin?** ☐ ☐
**Have you ever had any lung or breathing problems?** ☐ ☐

If yes, describe:

**Do you have a history of asthma or wheezing?** ☐ ☐
**Do you have any kidney or bladder problems?** ☐ ☐

If yes, describe:

**Have you ever had any problems passing urine or emptying your bladder?** ☐ ☐

**Do you have any stomach or bowel problems?** ☐ ☐

If yes, describe:

**Do you have difficulty swallowing food or drinks?** ☐ ☐
**Do you have any known Thyroid problems?** ☐ ☐
**Do you have Diabetes?** ☐ ☐

If yes, current treatment?

**Is there a family history of diabetes?** ☐ ☐

| **Question:** | Yes | No | | |
|---|---|---|---|---|
| Do you smoke? | ☐ | ☐ | Number per day? | ☐ |
| Are you a former smoker? | ☐ | ☐ | When did you stop? | ☐ |
| Do you drink alcohol? | ☐ | ☐ | Drinks per day? | ☐ |
| Do you take any recreational drugs? | ☐ | ☐ | | |
| Do you have high cholesterol? | ☐ | ☐ | | |
| Do you have high or low blood pressure? | ☐ | ☐ | If yes, which one? | ☐ |

**Is there anything else that you feel should be brought to our attention?**

If yes, please explain:

**Have you had any previous pathology, x-rays or investigations? Please list:**