Dr Melinda Pascoe - Patient Questionnaire

PATIENT DETAILS Title (Circle) Mr/Mrs/Miss/Ms/Mast/Dr **Surname**_____

First Name_____ Preferred Name_____

Date of Birth_____/_____/_____ Height_____cm Weight_____kg

CONTACT DETAILS

ADDRESS_____

Mobile Number_____Home_____ **Email**_____

NEXT OF KIN _____Best Contact_____ Relationship_____

MEDICARE/CONSESSION/HEALTH FUND DETAILS

Medicare Number/DVA_____ Ref_____ Expiry_____/_____

*10 numbers *number next to name

Pension Type (circle if applicable)

Pension Card / Health Care Card / Commonwealth Seniors Health Card / Disability

Number_____ Expiry_____

Health Fund (circle) YES/NO Name of fund _____

REFERRING DOCTOR

Name_____ **Clinic**_____

Local GP (if different from above)_____

Please provide reports to the following doctors/specialist in addition to above mentioned:

_____

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 you 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. **I consent to Dr Melinda Pascoe collecting my health information. I also consent to my health providers accessing my health information relevant to any of my health needs. 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 you personal health information at any time.

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 you nearest Accident and Emergency Department or to your general practitioner. It is your responsibility to ensure that the recommended appointment/s or test/s be made and attended. It is important that you understand these recommendations have been made in the best interest of your health. If you decide not to follow Dr Pascoe's advice, no responsibility is taken for your health outcomes.

I have read the above Practice Policy and agree to abide by this.

Name_____Sign_____Date____/_____/_____

I consent to receiving SMS reminders (please tick) **Yes** ☐ **No** ☐

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: