

**Patient Information Sheet (Please print)**

**Personal Details:**

Name:...../...../.....  
Surname Given Names Title Date of Birth Age

Address:.....Postcode.....

Telephone: Home.....Work.....Mobile.....

Occupation:.....Email.....

Nearest Relative: Name.....Relationship.....Phone.....

Referring Doctor:.....Address.....

Family Doctor: (if different).....Address.....

**Health Fund Details:**

Medicare No.....Patient No.....Valid til.....

Pension.....Repat. No.....

Health Fund: Yes No Name of Fund .....Member No.....

**Health Questionnaire:**

To assist us to provide the safest possible care for you, would you please inform us about your medical history.

Do you have any Medical Illnesses?.....

Do you take any Medications, including Aspirin, Vitamins and Natural/Herbal products? .....

Are you Allergic to any Medication, Antiseptics, or Products?.....

Do you have a History of the Following? (Tick)

Asthma	Rheumatic Fever	Contact Lenses	Cold Sores
Diabetes	Healing Problems	Blood Clots	1Arthritis
Hepatitis	High Blood Pressure	Bad Scars	1Heart trouble
Wound Infections	Spinal/neck Problems	HIV/AIDS Exposure	

Do you use any Recreational Drugs?.....

Daily Intake Smoking?..... Daily Intake Alcohol?.....

Do you have any Psychiatric or Psychological problems, or have you seen a counsellor for Mental Health Problems?  
.....

Have you had any Previous Operations?.....  
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Have you ever had any problems with Previous Operations or Recovery from an Operation?.....

Have you or a Family Member ever had Problems with any Local or General Anaesthetic?.....

Have you or a Family Member ever had Problems with excessive Bleeding for any reason?.....

Have you ever been involved in Civil Litigation (sued anyone) or made a Workers Compensation or Third Party (Motor Vehicle Accident) Claim? Please Provide Details.....

**Photography Consent:**

Circle

I give permission for Clinical Photographs to be taken as Part of my Consultation Yes No

My Clinical photographs may be used for Medical Educational Purposes (Doctors/Nurses/Med Students only) Yes No

My Clinical Photography may be used for Public Education Purposes Yes No

I give Permission for details of my consultation to be used in communication with other Health Care Professionals who are involved in my care Yes No

**Where did you hear about Silkwood Medical?**

Referring Dr / Other Dr: Name .....

Word of Mouth: (Tick)  Friend  Relative  Other .....

Events:  The High Tea

Advertising Material (Tick)

Magazine:  Cosmetic Surgery Mag.  Vogue  Madison  Marie Claire  Harpers Bazaar  Woman's Day  New Idea  Who  Good Health & Medicine  NW  Cosmo  Cleo  Famous  OK  Readers Digest  Other .....

Newspaper:  Sydney Morning Herald  Essential Magazine  Sunday Magazine  The Sydney Magazine  MX  Good Weekend

Television:  BodyWorks  A Current Affair  TodayTonight  Sky News  ABC  Other.....

Radio:  Mix 106.5  Nova 96.9  2DayFM

Yellow Pages:  White Pages:

Internet:  Google  Yahoo  Other search engine .....

Have you visited our website, [www.silkwoodmedical.com.au](http://www.silkwoodmedical.com.au)? Yes No

Are you interested in Receiving Promotional Material from Silkwood Medical including special offers? Yes No

Thank you for Providing Us with this information.

**Signature:**.....**Date**.....