Patient Details Form

Name:_____ DOB: _____

Medicare number: _____ Ref: ___ Exp: _____

Age Pension Card Number: _____ Exp: _____

Disability Card Number: _____ Exp: _____

DVA Card Number: _____ Colour: _____

Address: _____

Suburb: _____ Post code: _____

Home Number: _____ Mobile: _____

Email: _____

Emergency contact:
Name: _____

Phone number: _____ Relationship: _____

Family History: (please circle)

Mother: Diabetes High Blood Pressure Heart Disease Stroke Bowel Cancer

Father: Diabetes High Blood Pressure Heart Disease Stroke Bowel Cancer
Prostate Cancer

Brother: Diabetes High Blood Pressure Heart Disease Stroke Bowel Cancer
Prostate Cancer

Sister: Diabetes High Blood Pressure Heart Disease Stroke Bowel Cancer

Marital Status: Single Married Divorced Separated Defacto Widowed

Occupation: _____

Average number of **days per week** that you consume **alcohol**: _____

Average number of **standard drinks** consumed on those days: _____

Smoking: (Please circle) Never smoked
Current smoker Average number per day _____
Ex-smoker When did you quit _____

Please list any <u>allergies</u> to medications: _____
_____
_____

Significant past illnesses:
_____
_____
_____
_____

Significant past surgery:
_____
_____
_____
_____

Current medications:

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____