



Patient Medical Update

All information on this form is, and will remain, strictly confidential under the Privacy Act 1988

Patient Information

Surname: _____ Given names: _____

Title: _____ Date of Birth: ____ / ____ / ____ Occupation: _____

Home or Postal Address: _____ Postcode: _____

Home Phone: _____ Mobile: _____ Work Phone: _____

Email: _____ *Preferred contact for appointment reminder (please tick one)*

Emergency contact person

Name: _____

Phone: _____

Health fund information (if applicable)

Fund Name: _____

Membership No.: _____

Medical history update

Have you ever had, or do you suffer from, any of the following? Please tick ONLY those that apply:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anaemia/Blood disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Steroid therapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stomach issues |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting disorder | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stress disorders |
| <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Gastric banding / Lap band | <input type="checkbox"/> Prosthetic | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone disease / Osteoporosis | <input type="checkbox"/> Heart disease / Murmur / Stent | <input type="checkbox"/> Prosthetic implant / Joint replacement | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Brain shunt / injury / surgery | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Psychiatric condition | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> HIV | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tumours |
| | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sinus problems | |

How do you rate your overall GENERAL HEALTH? Poor Fair Good Excellent

If you respond 'yes' to any questions in this group, please provide more information in the space provided.

Are you currently taking any pills, medications, or supplements? No Yes→ _____

Do you have any allergies to antibiotics, medications, or other substances? No Yes→

Have you had any serious illnesses since your last visit? No Yes→ _____

Are you expecting to undergo any surgery or treatment in the next six months? No Yes→ _____

Are you taking any medication for any bone disorder? No Yes→ _____

Do you have other medical conditions that you have not listed above? No Yes→ _____

Do you smoke cigarettes or other recreational drugs? No Yes→ *How many per day?* _____

Females please also answer these questions:

Are you currently, or do you think you might be, pregnant? No Yes→ *Likely due date?* _____

Are you currently breastfeeding? No Yes

Signature: _____

Date: / /