PERSONAL DETAILS

TITLE: ○ Mr ○ Mrs ○ Ms ○ Miss ○ Mast GENDER: _____

SURNAME: _____

GIVEN NAME: _____

ADDRESS: _____

SUBURB / POSTCODE: _____

PHONE: (H) _____ W/M: _____

EMAIL: _____

DOB: _____ MARITAL STATUS: _____

OCCUPATION _____

NEXT OF KIN

NAME: _____ DOB: (if parent) _____

ADDRESS: _____

PHONE: _____ RELATIONSHIP TO YOU: _____

REFERER DETAILS:

REFERRING DOCTOR: _____

REGULAR GP (IF DIFFERENT): _____

MEDICARE / HEALTH FUND DETAILS / DVA (Veterans Affairs)

MEDICARE NUMBER: _____ REF: _____ EXPIRY: _____

HEALTH FUND: _____ MEMBERSHIP #: _____

MEMBERSHIP OVER 12 MONTHS: YES / NO (PLEASE CIRCLE)

FUND EXCESS: YES / NO (PLEASE CIRCLE) AMOUNT: $ _____

DVA CARD NUMBER: _____ GOLD / WHITE (PLEASE CIRCLE)

HOW DID YOU HEAR ABOUT US? _____

Could you be pregnant?	YES / NO
Do you use Contraceptives?	YES / NO
Do you smoke?	YES / NO / SOCIALLY
In the past 6 months, have you had the following: • Blood Tests • Specialist Appointment – reason? • Major health problems? • Hospital Admission?	
Previous Surgery:	
Do you have any Prostheses? (joint replacements/implants)	
Have you had Cardiac Stenting / Valve or Bypass Surgery?	
Do you have a Pacemaker?	
Are you on blood thinning medication? If yes, did a GP or Specialist prescribe it?	
Do you take Cortisone Tablets / Injections or Anti-inflammatory Drugs?	
Do you have Hypertension?	
Do you have Diabetes? If so, which type?	
Do you have Thyroid issues?	
Do you have any Allergies? Food/Medication/Tapes/Non-prescription drugs.	
Have you had Covid Vaccinations?	YES / NO
Have you been infected with Covid in the past 4 – 6 weeks?	YES / NO If yes, date _____
Are you aware you must have someone to stay with you for 24hrs following surgery?	YES / NO
Are you aware that you are not allowed to drive for at least 24 hours?	YES / NO

Dr Arianayagam records his consultations to assist with record keeping. Your signature below confirms your consent and that all information provided on this form is correct. If you have any concerns, please speak with the reception staff.

SIGNATURE: **DATE:**

CONSENT

RECORDING OF CONSULTATIONS

As part of your visit with us today, Dr Arianayagam records his consultations. This is then stored in your consultation notes as an MP3 file.

◯ I agree to my consultation being recorded

Signed: _____

Patient Name: _____

Date: _____

PHYSICAL EXAMINATION

If you are consulting with Dr Arianayagam today regarding any part of your body that is covered by clothing, you may be asked to undress.

For your privacy, you will offered a dignity sheet to use during the examination.

Dr Arianayagam will ask that one of his staff accompany him during the examination, for both your protection as well as his own.

Pre-operative photo's may also be taken during this examination.

◯ I consent to an examination being undertaken, which may involve partial or full removal of my clothing

◯ I consent to pre-operative photographs being taken, which may involve partial or full removal of my clothing

Signed: _____

Patient Name: _____

Date: _____