Your Personal Details

Your name______________________________ **DOB**____/____/_____

Address

____

Telephone ______________________ **SMS** Y or N (please circle)

Gender ____________

Current occupation_________________________

Previous occupation if retired ______________________________

Medicare number ___________________ **ref**___ **Exp** ____________

Private Health Fund__________________**Fund No**_______________

DVA ______________

Pension No :_______________ **Expiry:**____________

Please tick - ☐ **Aboriginal origin** ☐ **Torres Strait Island origin**

Your General Practitioner

____

Your Next of Kin

Name ____________________ Telephone No __________________

Relationship _______________Permission to contact Y or N (circle)
(If unable to contact you or emergency)

Medications list (or attach list)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Allergies to any medications

____

Major illness/hospitalisations - last 5 years **Hospital**

1. ____________________ ____________________
2. ____________________ ____________________
3. ____________________ ____________________
4. ____________________ ____________________
5. ____________________ ____________________
6. ____________________ ____________________

Please tick the following if you ever had; if you answer yes please write AGE or YEAR started

	Yes	**No**		**Yes**	**No**
High blood pressure			Miscarriages (female)		
High cholesterol			Broken bones after age 50		
Stomach ulcer			Severe allergies		
Bowel problems			Psoriasis		
Kidney problems			Gout		
Diabetes			Eye problems		

Please tick YES if there is family history, if yes, give relationship

		Relationship			Relationship
Rheumatoid arthritis			Osteoporosis		
Lupus/SLE			Ankylosing Spondylitis		
Crohn's/ulcerative colitis			Psoriasis		

Your Social History

Have you ever smoked? Y or N (circle) if yes approximate number per day? _______

How many years have you smoked? If stopped, when____________________

How much alcohol do you drink a day? (N/A if you don't drink)________________

Marital status ____________________

If married, health of spouse (circle) Good Poor If poor, give details______________________________

Health of others at home (circle) Good Poor If poor, give details______________________________

I give consent for a chaperone to be present during physical examination when required ________________________

I have read and understood the privacy policy.

Due to the Privacy & Confidentiality Act, you are required to authorise any correspondence sent via your email provided:

Email:____

The details given above are correct and true

Date_____________________

Signature_____________________________________

Release of Information

I, ____________________ ______________________________ ___/___/___
(First Name) (Surname/Family Name) D.O.B

Of ____
(Your address)

Hereby consent to give permission for all relevant medical details, medical report/s and clinical notes concerning myself to be supplied to Paradise Arthritis & Rheumatology.

Patient Signature:_________________________ **Date:**______________________

Practice Manager: Maureen Hedges

- ☐ **Assoc. Prof Dr Jennifer Ng**
- ☐ **Dr Jacklyn Chay**
- ☐ **Dr Sateesh Shankaranarayana**
- ☐ **Dr Andrew Finch**
- ☐ **Dr Gerald Tracey**
- ☐ **Dr Sonam Joshi**
- ☐ **Dr Armi Salonga**

Paradise Arthritis & Rheumatology
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