Joondalup ENT

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Adult & Paediatric Ear, Nose and Throat Surgeons

Confidential Patient Registration Form

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Master

Surname:_____

Given Names: _____

Address:_____

Suburb:_____State:_____Postcode:_____

Date of birth:_____Email: _____

Phone (H):_____(W):_____(M):_____

Medicare No:_____ REF No*:_____Expiry Date: _____

If the patient is a child under the age of 18, please provide details of one parent or caregiver that is listed on the same Medicare card

Parents Full Name :_____ Date of birth:_____

Medicare No:_____REF No*:_____Expiry Date: _____

Pension No:_____

Veterans Affair No:_____ ☐ Gold ☐ White

Do you have private health insurance? ☐ Yes ☐ No Does this cover hospital admission? ☐ Yes ☐ No

Have you been a member for more than 12 months? ☐ Yes ☐ No If answered **NO**, please advise start date:_____

Private health fund:_____ Membership No: _____

Emergency contact / next of kin: _____

Relation:_____Phone:_____

Do you give permission to discuss your details with the above? ☐ Yes ☐ No

Usual family doctor name **(if different Practice from referring doctor)**: _____

GP Address:_____ Suburb: _____

Patient consent to collect and disclose information:

This practice collects information from you for the primary purpose of providing quality health care, to properly advise and treat you. We are committed to best practice in relation to the management of information we collect for you and this practice has developed a policy to protect patient privacy in compliance with privacy legislation.

This information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources such as other doctors, health providers or hospital.

I understand that I am not obliged to disclose my personal information requested of me but that my failure to do so may compromise the quality of the health care and treatment given to me.

I understand that I am entitled to access my own health care records except where access might be legitimately withheld. I understand that I will be given an explanation in these circumstances. I understand that I may withdraw my consent to the use and disclosure of my personal information (except where legal obligations must be met). For more information please refer to our website www.drpeterfriedland.com.au

Account information:

I agree and acknowledge that I am responsible for payment of medical accounts on the day of service. I understand that I will be responsible for payment of debt collection fees applied to overdue accounts. I understand that a cancellation fee of $80.00 may apply for less than 24 hours' notice to cancel an appointment or failure to attend an appointment.

Signature:_____Date: _____ ***PLEASE TURN OVER PAGE AND COMPLETE***

Presenting Complaint

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What is the reason for your visit? _____

Past Medical history *Please check any problems you have had.*

- ☐ Anxiety
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary embolism
- ☐ Cancer
- ☐ Hearing Loss
- ☐ Substance Abuse
- ☐ Clotting disorder
- ☐ COPD
- ☐ Heart Attack
- ☐ Bleeding Disorder
- ☐ Emphysema
- ☐ Stroke
- ☐ Cirrhosis
- ☐ kidney Disease
- ☐ Migraine Headaches
- ☐ Asthma
- ☐ Diabetes Mellitus
- ☐ Skin Cancer
- ☐ Chronic Lung Diseases
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Palpations
- ☐ Depression
- ☐ Seizures
- ☐ Chest Pain
- ☐ Hepatitis
- ☐ Syncope/fainting
- ☐ Meningitis
- ☐ Other (Please Specify) _____

Past Surgical History *Please check any surgeries you have had and also approximate age of surgery.*

- ☐ Ear surgery (left or right side? List procedure and approximate date)

_____

- ☐ Adenoidectomy
- ☐ Sinus Surgery
- ☐ Tonsillectomy
- ☐ Facial Surgery
- ☐ Heart Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Radiation Therapy
- ☐ Brain Surgery
- ☐ Cholecystectomy
- ☐ Valve Replacement
- ☐ Other Surgery (Please Specify) _____

Family History *Please check any family conditions and approximate age of problem if know.*

- ☐ Anaesthesia Problems
- ☐ Clotting Disorder
- ☐ Bleeding Disorder
- ☐ Hearing Loss
- ☐ Cancer
- ☐ Heart Disease
- ☐ Other (Please Specify) _____

Medications

List any medications you are currently taking below. Please indicate dose and frequency if known. Include any supplements, herbal and over the counter medication.

Medication	Dose	Medication	Dose

Social History

Relationship Status: _____

How Many Children: _____

Occupation: _____

Do you drink alcohol? ☐ Yes ☐ No Type: _____ Amount Per Day: _____

Do you smoke? ☐ Yes ☐ No Amount Per Day: _____

Are you a former smoker? ☐ Yes ☐ No When Did You Quit? _____

Do you take recreational drugs? ☐ Yes ☐ No If yes, please provide details: _____

Systems Review Please *check any current problems.*

- ☐ **Constitutional**: Anorexia, significant reduced food intakes, chills, fatigue, fever, malaise (not feeling quite right), night sweats, sweats, weight loss
- ☐ **Eyes:** Diplopia (double vision), lid erythema (redness), conjunctival redness (red eye), visual disturbance or loss
- ☐ **Ear, Nose & Throat:** Nasal obstruction, nasal drainage, nosebleeds, snoring, throat pain, voice change, dysphagia (trouble swallowing)
- ☐ **Respiratory:** Asthma, chronic bronchitis, cough, haemoptysis (coughing up blood), pneumonia, shortness of breath, stridor (noisy breathing in), wheezing (noisy breathing out)
- ☐ **Cardiovascular:** Chest pain/pressure/discomfort, shortness of breath on exertion, palpitations, leg swelling, trouble breathing lying down, fainting
- ☐ **Gastrointestinal:** Ulcers, reflux/heartburn, dysphagia (trouble swallowing), vomiting, diarrhoea
- ☐ **Genitourinary:** Kidney disease, nocturia (urinating at night), urinary frequency
- ☐ **Skin/Breast:** Skin lesion, breast lump
- ☐ **Blood/Lymph:** Bleeding, easy bruising, blood clots, swollen lymph nodes
- ☐ **Musculoskeletal:** Arthritis/joint inflammation or pain, bone pain
- ☐ **Neurological:** Stroke, seizure, weakness, numbness, paraesthesia (burning or prickling sensation), speech problems
- ☐ **Psychological:** Anxiety, depression
- ☐ **Endocrine:** Cold/heat intolerance, excessive thirst
- ☐ **Allergy, immune:** Hay fever, anaphylaxis, auto immune problem, immune suppression drugs