



## MEDICAL HISTORY – LESION PATIENT

Welcome to Hunter Plastic Surgery. Please complete this form in preparation for your consultation with Dr Moncrieff.

Full Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address and post code: \_\_\_\_\_

Email address: \_\_\_\_\_

*(Please let us know if we may email your quote!)*

Which numbers may we call you on regarding results, recalls or to change an appointment?

Telephone numbers: (mobile) \_\_\_\_\_ (home) \_\_\_\_\_

Can we leave messages for you identifying the surgery as the caller? YES/NO

I authorise the following person to take messages regarding recall, reminder or change of appointment:

Nominated Person \_\_\_\_\_ (contact phone number) \_\_\_\_\_

### Memberships

Health fund: \_\_\_\_\_ Membership number: \_\_\_\_\_

Medicare number: \_\_\_\_\_ Exp date: \_\_\_\_\_

What number are you on the Medicare Card (1-6)?: \_\_\_\_\_

Veterans Affairs number: \_\_\_\_\_ Exp date: \_\_\_\_\_

### Medical conditions and treatment

Do you have any of the medical conditions listed below? Please circle YES or NO.

ANGINA (heart pain)	YES/ NO	HEPATITIS (liver virus or disease)	YES/ NO
HYPERTENSION (high blood pressure)	YES/ NO	HIV/AIDS	YES/ NO
DIABETES (high blood sugar)	YES/ NO	CANCER	YES/ NO
RENAL DISEASE (kidney disease)	YES/ NO	CHICKEN POX or SHINGLES	YES/ NO
RESPIRATORY ILLNESS (lung problems)	YES/ NO	RECENT VIRAL ILLNESS (flu-like)	YES/ NO
BLEEDING DISORDER	YES/ NO		

If you answer YES for any of the above, please describe your treatment.

\_\_\_\_\_

\_\_\_\_\_

Have you had experienced any of the medical issues listed below? Please circle YES or NO.

DEEP VEIN THROMBOSIS (blood clots in the leg)	YES/ NO	HEART ATTACKS	YES/ NO
PULMONARY EMBOLISM (blood clots in the lung)	YES/ NO	DIFFICULTIES WITH ANAESTHESIA	YES/ NO
INFECTIONS (such as MSRA)	YES/ NO		

If you answer YES for any of the above, please provide details and treatment.

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Please list any major operations you have had.

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Did you suffer any major complications from past operations?

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If you have a condition not listed above, please describe.

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### Medications

Which medications are you currently taking (prescription, over the counter or herbal)? Please take special care to list any blood thinners such as aspirin, Warfarin and fish oil.

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Are you allergic to any medications? YES/ NO

If YES, please specify \_\_\_\_\_

### Habits

**Alcohol:** Never \_\_\_\_\_ OR average number of drinks each day \_\_\_\_\_

**Smoking:** Never \_\_\_\_\_ OR average number each day \_\_\_\_\_ OR if you quit in the last 5 years, when did this happen?) \_\_\_\_\_

### Agreement and signature

In order to comply with the Privacy Laws (Privacy Act Amendments – Private Sector – Act 2000) your agreement to the following statement is required:

(Patient or parent to complete)

I \_\_\_\_\_ agree to allow Hunter Plastic Surgery access to all relevant information regarding my medical conditions. I understand that Hunter Plastic Surgery may be required to forward information about my medical condition or history to other health care providers. I understand that to provide the highest medical care, my clinical records may be accessed or reviewed by staff in this practice.

Signed: ..... Date: .....

Please remember hand this form to Reception upon completion.