HUNTER PLASTIC SURGERY
Real results. Expert care.

DR NICHOLAS MONCRIEFF
PLASTIC, RECONSTRUCTIVE & COSMETIC SURGEON
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MEDICAL HISTORY FORM – COSMETIC 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: ____

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) _______________

How did you hear about Hunter Plastic Surgery? __________________________________

Memberships

Health fund: _______________________ **Membership number:** _______________

Medicare number: _________________________________ **Exp date:** ____________

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

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

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

____

____

Please list any major operations you have had.

____

____

Did you suffer any major complications from past operations?

____

____

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

____

____

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.

____

____

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

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

I agree to allow Dr Moncrieff access to all relevant information regarding my medical conditions. I understand that Dr Moncrieff 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.

Use of email – I agree to the use of my email address for correspondence relating to Hunter Plastic Surgery including marketing material. Hunter Plastic Surgery will never provide these details to third parties and I can unsubscribe at any time. YES ☐ NO ☐

Payment policy – I understand that if I proceed with a surgical procedure that all payments are required 14 days before the operation or the surgery will be cancelled.

Photograph policy – All cosmetic patients have before and after photos taken which are kept with your records. On some occasions, Dr Moncrieff will use these photos, with reasonable identity protection, for educational or marketing purposes. If you would prefer your photos not to be used in this way, please tick this box. OPT OUT ☐

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

Please remember hand this form to Reception upon completion.