# CONFIDENTIAL PATIENT QUESTIONNAIRE

The following information is requested to ensure that you are correctly identified in our records, to save you time, and to assist us in giving you the best possible care. All of the information which you provide will be treated as being strictly confidential: this practice conforms with the National Privacy Principles, and a copy of our Privacy Policy is available on request.

Please complete this questionnaire before arriving for your appointment or arrive 10 minutes early for your appointment and complete it at the clinic.

Title: _____ First Name: _____Surname: _____

Date of Birth: _____ Age: _____

Address:

_____

_____

Postal Address (if different from above):

_____

_____

Phone (Home): _____(Work): _____Phone (Mobile): _____

Occupation: _____ Email Address: _____

Emergency Contact Details (name and day/night time telephone numbers):

_____

Medicare: _____ Expiry: _____ Ref: _____

Veterans Affairs No: _____ DVA Gold Card: _____

Referring Doctor: _____

General Practitioner (if different to above): _____

Specialist(s) you are currently seeing: _____

The aim in this practice is for patients to be well-informed about their condition, and about any recommendations made for treatment. It is important therefore for you to say at the time if there is anything you do not understand, or about which you wish to know more. An exception to this occurs if you are referred for insurance or medico-legal assessment by a third party, when we are not at liberty to discuss your diagnosis or management.

PATIENT ACKNOWLEDGEMENT AND CONSENT

I have read the information set out on this form. I agree with this information and hereby consent to my medical details including any medical reports being released to my referring medical practitioner(s) and to any other medical practitioner(s) who treats me now or in the future including any other medical practitioner to whom Coastal Neurophysiology refers me. My consent is based upon the understanding that such release is intended to be in the best interest of my health.
I hereby give authorisation for any of my past medical records to be released to Coastal Neurophysiology. To the best of my knowledge and belief all of the information I have provided is true and correct.

Signed By: _____ Date: _____

**What are your main symptoms at present (relating to present referral)?**

_____
_____
_____
_____

**General Medical History: (please circle where relevant)**

What is your current body weight? _____ kg What is your current height? _____ cm

Amount of weight gain in past 12 months: _____kg or amount of weight loss past 12 months: _____kg

- High blood pressure If yes, is this medicated? Yes/No
- High cholesterol and/or high blood fats If yes, is this medicated? Yes/No
- Diabetes If yes, what is your average BSL (_____) and how long have you had diabetes? (_____years)
- Heart attack (myocardial infarction), heart failure, ischaemic heart disease, atherosclerosis, cardiac bypass surgery, cardiac angioplasty (stent), peripheral oedema (right heart failure), valve replacement, stroke, TIA, palpitations, cardiac arrhythmia
- Obstructive lung disease (e.g. COPD, asthma). chest wall disease (e.g. kyphoscoliosis), hypercapnic respiratory failure (increased CO2), emphysema
- Kidney disease, kidney stones, bladder problems
- Gastric or duodenal ulcer, bowel disorder, liver disorder
- Hepatitis A, B, C; HIV; currently or previously on treatment? Yes/No
- Anaemia, excessive bleeding, other blood disorders
- Thyroid disorder, other endocrine disorder
- Anxiety, depression, other psychiatric disorder
- Arthritis, joint or bone disorder
- Neuromuscular disease (e.g. muscular dystrophy; fibromyalgia, neuropathy)
- Epilepsy, seizures, blackouts, other neurological disorder
- Smoking If yes (number per day: _____) Have you previously smoked (age started: _____ age ceased: _____)
- Alcohol consumption if yes, amount? Min: _____ Max: _____ Avg: _____

**Any additional comments:**

_____
_____

Do you take any non-prescribed or recreational drugs? (please specify) _____
Do you have any allergies? if yes, please list_____

**Current medications:**

| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Family History:**
Please indicate any neurological family diseases:
Mother: _____ Father: _____
Maternal Grandmother _____ Paternal Grandmother _____
Maternal Grandfather _____ Paternal Grandfather _____