PRIOR TO SEEING DR GRAZE – PLEASE COMPLETE THE FOLLOWING

((MR / MRS / MS / MISS / DR) SURNAME: …….

GIVEN NAMES: …….....

PREFERRED NAME…….

ADDRESS : …….

…… ……POST CODE .....DATE OF BIRTH: ……./……./…….

TEL NO. (Home) ……. ……(Work) ……..……

(Mobile) ……..…….(Email)……..

Next of Kin:……Relationship…….Mobile……..……..

NAME OF REFERRING DOCTOR: ……...……..

NAME OF USUAL GENERAL PRACTITIONER……..

PRIVATE HEALTH FUND ……Are you covered for Private Hospital ? YES / NO

MEMBER NUMBER …….

MEDICARE No: ……..... FAMILY REF NO……EXPIRY DATE ……..

ARE YOU AN AGE PENSIONER? YES / NO ……Exp……..

ARE YOU A VETERANS' AFFAIRS PATIENT ? YES /NO - File No…….

ARE YOU A WORKCOVER PATIENT ? YES / NO - Claim No…….

Work cover Insurer Details…….

How did you hear about us??

GP / HOSPITAL *FRIENDS / RELATIVES* *YELLOW PAGES*

PHYSIOTHERAPIST *WEB SITE* *OTHER* ……

Privacy Policy - Your consent is required for this practice to disclose information to others involved in your health care management, including treating doctors and specialists outside this practice, any medical tests or reports that are relevant to your ongoing treatment.

Patient/Guardian……Date……..

Please complete the 2nd page also

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PAST MEDICAL HISTORY: It is important to list **relevant** current or past problems

	Yes/No	GIVE DETAILS
1. Heart and Vascular System		
2. Lungs		
3. Digestive System		
4. Urinary System		
5. DVT / Pulmonary Embolus		
6. Specific ongoing joints, muscles or bone conditions		
7. Brain and Nervous system		
8. Previous hospitalisation or surgery		
9. Are you Diabetic?		
10.Are you a smoker… If so how many cigarettes per day		

Medications?
Is there a list of **current medications** on your referral?? If not please list.

……

Are you taking? ASPIRIN Yes / No WARFARIN Yes / No

CLOPIDOGREL (Plavix , Iscover) Yes / No

Family history of medical problems? ……..

Allergies? (give details) ……

……..

OCCUPATION …… ?? RIGHT OR LEFT HANDED……AGE……

Drs Notes
Diagnosis/Plan