DR MURRAY BLYTHE | PATIENT INFORMATION & CONSENT FORM

PERSONAL DETAILS:

Dr Mr Master Mrs Ms Miss Other

First Name:	Surname:	Date of Birth:
Address:	Suburb:	Postcode:
Email Address:		
Home Number:	Work Number:	Mobile:
Medicare Number:	Ref (Number next to your name):	Exp:
Private Health Fund:	Membership Number:	
Does your Private Health Fund cover **hospital admission**?		YES / NO

GENERAL PRACTITIONER DETAILS:

Usual General Practitioner:

Name of Surgery:

EMERGENCY CONTACT / NEXT OF KIN DETAILS:

Name:	Relationship to Patient:
Home Number:	Mobile Number:

DEPARTMENT OF VETERANS' AFFAIRS:

Card Number:	Card Type (Please select):	GOLD / WHITE

AUTHORITY TO RELEASE MEDICAL / PERSONAL INFORMATION & FEE AGREEMENT:

I authorise and request Dr Murray Blythe to release to my referring medical practitioner, and/or other medical practitioners who may be involved with my medical care, now and in the future, all such medical reports, personal information and documentation relevant to my medical care, including procedure reports, test results and hospital admissions, that may be required. I agree that I am responsible for the payment of all fees to Dr Murray Blythe for consultation, surgery or any reports requested on my behalf for medicolegal reasons.

Signed:	Dated:

DR MURRAY BLYTHE | PATIENT HISTORY

Preferred Name:	Occupation:	Age:
Height: cm/ft	Weight: kg	

DO YOU HAVE (PLEASE SELECT):

Heart problems:	YES / NO	If yes, please provide details:
Diabetes:	YES / NO	If yes, please provide details:
Stomach ulcers/reflux:	YES / NO	If yes, please provide details:
Kidney problems:	YES / NO	If yes, please provide details:
Are you a smoker:	YES / NO	If yes, please provide details:
Previous blood clot/DVT/PE:	YES / NO	If yes, please provide details:

Are you on Aspirin, Warfarin or any other blood thinning medications? YES / NO

If yes, please list:

Do you have any allergies to any medications? YES / NO

If yes, please list:

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

PLEASE LIST ANY PREVIOUS RELEVANT OR MAJOR OPERATIONS:

PLEASE LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING PAIN KILLERS THAT ARE NOT PRESCRIBED:

(**DO NOT** ATTACH A LIST **OR** WRITE 'SEE LIST')

Name of Medicine/Tablets:	Dose/Amount:	Time Taken: