Sydney Sinus & Allergy Centre

Patient Information Sheet

Please indicate: Dr / Mr/Mrs/Miss/Master/Other...……

First Name:……..…….....**Surname**:……

Address:…… .....

…….Post Code……

Date of Birth……..……Male/Female:……...

Home Phone:……Work Phone……**Mobile**…….....

Account Holder's Name:……..R'ship to Patient:……..
(For patients under 16 years of age)

DOB: ……Ref. No on Medicare Card……..(e.g. 1, 2, 3 etc)

Medicare No…..…… Expiry Date……..……...……Ref. No:…….....(eg: 1, 2 etc.)

Health Fund…….Membership Number…….……...

Pension Card No:……Expiry Date……

DVA No:……..White/Gold Card……

For Medicare Rebate (Optional)

Account Name:……BSB:……. A/c No:…….
(Direct Deposit To Your Account)

Medicare cheque sent direct to patient ( ) please tick if required

Name of Local Doctor (if different from Referring Doctor)
Dr……Phone……..

Address……
…….....

WORKERS COMPENSATION: Insurance Co: ……..Claim No: ……

Employer: ……

Address:

……

Phone No: ……Contact Person: ……Date of Injury: ……...

Consent:
This practice will collect information that is necessary to properly advise and treat you/your child. With your consent (as per Privacy Act 1988), this practice will use and disclose your information for purposes such as other health care providers, obtaining advice on treatment options, billing, medical defence notification obligations or where legally required to produce records. Your health information may also be used for research purposes for the advancement of medical science, however all information that identifies you will be removed to protect you. You are entitled to access your file upon request. If you require any further information, please discuss this during consultation.

Signed……Dated…….....

NEW PATIENT INFORMATION

What medical problem(s) brought you here today: _____
_____
_____

Please describe the location of your problem:
Ears ☐ Nose /Sinuses ☐ Throat ☐ Voice ☐ Snoring ☐
_____

When did you first notice the problem: _____
_____
_____

Have you received treatment(s) for this (these) problem(s) yes ☐ no ☐
If yes what and approximately when: _____
_____
_____
_____

Do you have or been treated in the past for:

ASTHMA	yes ☐ no ☐	_____
DIABETES	yes ☐ no ☐	_____
CANCER	yes ☐ no ☐	_____
REFLUX	yes ☐ no ☐	_____

List other MEDICAL problems that you have had in the past including dates, if possible

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any SURGERIES that you have had in the past including dates, if possible

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What Medications are you on right now

NAME	DOSE
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking a blood thinner? yes ☐ no ☐ _____
_____ _____

Do you have Allergies to any medications yes ☐ no ☐
Do you have other Allergies yes ☐ no ☐
If yes to either please list
_____
_____

Do you have a parent or sibling with any of the following problems?

Allergies: Yes ☐ No ☐ Heart Disease: Yes ☐ No ☐ Cancer: Yes ☐ No ☐ Hearing Loss: Yes ☐ No ☐

What is your occupation? _____

Are you: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Defacto ☐ Other ☐

Do you have any children? Yes ☐ No ☐ How many? _____

Have you ever smoked? Yes ☐ No ☐

If yes, how many years did you smoke? _____How many years ago did you quit smoking?_____

How much do you smoke?
☐ Less 10 per day ☐ 10 – 20 per day ☐ > 20 per day

Do you use any other kind of tobacco? Yes ☐ No ☐

If yes, what kind? Chewing tobacco ☐ Snuff/dip ☐ Cigars ☐ Pipe ☐ Other _____

Do you drink alcohol?: ☐ Never ☐ Rarely ☐ Socially (Several times a week or month) ☐ Daily

If you drink, what do you drink? Beer ☐ Wine ☐ Liquor ☐

If you **MAIN** problem is

For your	Nose / Sinuses	please also complete	-	SNOT22 Form **and** NOSE Form
For your	Voice / throat or swallowing	please also complete	-	The Voice Questionaire
For	Snoring	please also complete	-	The Epworth Sleepiness Scale

The above information is important to allow us to treat you properly. The questionnaires are an important guide to your progress so that we can ensure we are achieving the outcomes you desire and are also quality of life surveys used for ongoing research undertaken at this practice.

Signed by Surgeon: …….. Date: ……..