Kidney Stone Clinic

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KIDNEY STONE CLINIC
Est. 2009
www.stoneclinic.com.au

NAME _____ **Date of birth.** _____/_____/____
As it appears on your Medicare Card.

ADDRESS _____

TELEPHONE: (H) _____ **(W)** _____ **MOBILE** _____

HEALTH FUND: Yes [ ] No [ ] Public cover only [ ] MEMBERSHIP NO: _____

If Yes, Name of fund _____

PENSION No: _____ **(Age pension only) DVA Pens No:**_____**Gold / White**

***Your Patient number is the number next to YOUR name on the Medicare card.**

MEDICARE CARD Number	
***Medicare Patient No**	**M/care card expiry date**

The questionnaire below will help to assess your problem. Please be as accurate as you can. The information will be part of your medical records and remain entirely confidential.

MARITAL STATUS Single / Married / Divorced / Widowed / De-facto

OCCUPATION _____

What **MEDICATIONS** are you currently on? (Include **Over The Counter** types / herbals/ vitamins)

_____

_____

Do you take aspirin /warfarin / anti-inflammatories or other medications to thin your blood? Y / N

Are YOU **allergic** to any medications? YES/NO _____

Do you **SMOKE?** YES / NO / IF GIVEN UP –**WHEN?**_____

How much **ALCOHOL** do you drink in a **DAY or in a WEEK?** _____

Past ILLNESSES _____
(use back of page if req'd)
_____

Past OPERATIONS _____
(use back of page if req'd)
_____

WHY ARE YOU HERE TODAY?

[ ]	KIDNEY STONES	[ ]	Blood in urine
[ ]	Pain related to stones	[ ]	Frequency / Urgency
[ ]	Difficulty emptying bladder	[ ]	Getting up at night
[ ]	Recurrent urinary infections	[ ]	Pain or burning when passing urine
[ ]	Prostate Check / PSA	[ ]	**Other** _____

- Do **YOU** have any of the following conditions?

High blood pressure	[ ] Yes	[ ] No
Heart disease / Heart valve abnormality /Angina	[ ] Yes	[ ] No
Asthma / Bronchitis / Lung problems	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No
Kidney Disease-Impairment	[ ] Yes	[ ] No
Problems with the Nervous System / Spinal Cord	[ ] Yes	[ ] No
Easily bruise or bleed	[ ] Yes	[ ] No

- Any major illnesses in **your family**? **(eg, stroke, cancer, heart disease)** [ ]Yes [ ] No

Details_____

_____

- Have you ever had problems with an **anaesthetic?** [ ] Yes [ ] No

*** Please provide NAMES of other RELEVANT doctors- GP or Specialists, other than the one who referred you here today who require correspondence.**

Name(s) & Address(es): _____

_____

The Privacy Act (1998) requires medical practitioners to obtain consent form their patients to collect, use and disclose that patient's information. This practice will collect information that is necessary to properly advise and treat you. With your consent, this practice will use and disclose your information for purposes such as referral to other health care providers/hospitals, obtaining advice on treatment options, billing, medical defence insurance notification obligations or where legally required to produce records. You are entitled to access your files upon request. If you require further information, please discuss this during your consultation.

Signature …… **Date …..…/……../……**