NORWEST GI

TO ASSIST WITH YOUR VISIT TODAY, WOULD YOU KINDLY COMPLETE THE FOLLOWING DETAILS:

TITLE

SURNAME (same as Medicare card) .....

GIVEN NAME (same as Medicare card) ..... DATE OF BIRTH..... /..... /.....

ADDRESS.....

..... STATE..... POSTCODE.....

POSTAL ADDRESS.....

PHONE NUMBER HOME..... MOB..... ALTERNATE NO.....

EMAIL ADDRESS.....

MEDICARE NUMBER..... EXPIRY DATE .....

REFERENCE NUMBER..... OR

OVA NUMBER..... GOLD CARD YES ☐ NO ☐

DO YOU HAVE PRIVATE HEALTH INSURANCE ☐ YES ☐ NO

DO YOU HAVE HOSPITAL COVERAGE ☐ YES ☐ NO

FUND DETAILS

NAME OF FUND.....

MEMBERSHIP NUMBER.....

ARE YOU AN AGED PENSIONER? ☐ YES ☐ NO IF SO, PENSION NUMBER.....

Name of your GP: **(if not** referring Doctor) .....

Address of your GP: **(if not** referring Doctor) .....

NEXT OF KIN

NAME..... RELATIONSHIP.....

MOB PHONE NUMBER.....

This document is the start of the Doctor collecting information on you. We will collect health information to assist in the management of your care and collect information ta assist us in providing you with credit. We may share the collected information with other health providers that have treated you, or may treat you in the future. If they are to share information with us, this will also form part of your file.

☐ *I give my consent to the collection of information for these purposes.*

SIGNED.....DATE.....

☐ *Tick this box if you do not consent to sharing your informatin with other health practitioners.*

HEALTH QUESTIONAIRE

PLEASE CIRCLE IF you have or have you had:

High Blood Pressure ☐ Yes ☐ No

Do you Smoke7 ☐ Yes ☐ No
If so, how many per day? _____

Chest Pain or 'angina" ☐ Yes ☐ No

Heart Attack ☐ Yes ☐ No

Eg Heart valve, pacemaker ☐ Yes ☐ No

Lung problems needing hospital ☐ Yes ☐ No If yes - What type _____

Chronic Bronchitis or Asthma ☐ Yes ☐ No If yes - When _____

Reflux of acid or food
Heartburn/Hiatus hernia ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No If yes - Do you use Insulin? ☐ Yes ☐ No
- Do you use Tablets? ☐ Yes ☐ No

Blood clots in the leg or lung ☐ Yes ☐ No If yes - What type _____

Bleeding disorder ☐ Yes ☐ No

Have you previously had any
abdominal surgery 7 ☐ Yes ☐ No If yes - please list below

_____

_____

Are you allergic to:

- Latex ☐ Yes ☐ No
- Penicillin ☐ Yes ☐ No
- Sulphur ☐ Yes ☐ No
- Iodine ☐ Yes ☐ No
- Do you use a Puffer? ☐ Yes ☐ No

What tablets do you take? _____

_____

PATIENT SIGNATURE_____,**DATE**_____