THE Lung Health CLINIC

NEW PATIENT FORM

YOUR CONTACT DETAILS AND IDENTIFICATION

* Required Field

Title * ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss ☐ Prof.

Surname *

First Name * *(as per medicare card)* Middle Name

Known As * *(if different from above)* DOB * *dd/mm/yyyy* / /

Address *

Suburb * Post Code *

State * Country *

Mobile Phone No. Home Phone No.

Work Phone No. Home Fax No.

Email

Are you happy for email contact? ☐ Yes ☐ No

Public Hospital Medical Number *(if known)*

Would you like appointment reminders sent by SMS? ☐ Yes ☐ No

MEDICARE & PRIVATE INSURANCE DETAILS

Medicare Number * *(0000 00000 0)* The number in front of your name on your Medicare card *

Would you like us to electronically lodge your accounts to Medicare? ☐ Yes ☐ No

Private Health Fund ☐ HBF ☐ BUPA ☐ Medibank Private ☐ Other

Aged Person / Senior Health Care Card Number

Veteran's Affairs Number

Veteran's Affairs Card Color

EMERGENCY CONTACT DETAILS

Name Relationship

Address

Mobile Phone No. Home Phone No.

USUAL GENERAL PRACTITIONER

Dr's Name *

Dr's Clinic Name

Address

Suburb

Post Code

State

Country

Dr's Telephone

PERSONAL AIDS AND DEVICES

Do you wear a hearing aid? *(Please wear for your visit to us)* * ☐ Yes ☐ No

Do you use portable oxygen * ☐ Yes ☐ No

Do you use any other personal aids and devices, eg a wheelchair * ☐ Yes ☐ No

IMPORTANT MEDICAL INFORMATION

Please tick the relevant boxes if any of the problems listed are related to why you are coming to see us

- ☐ Abnormal finding on your Xrays/CT
- ☐ Allergies
- ☐ Asthma
- ☐ Breathlessness
- ☐ Chest Pain
- ☐ Chronic Chest Infection
- ☐ Collapsed Lung
- ☐ Cough
- ☐ Emphysema
- ☐ Fluid Around Lung
- ☐ Nasal / Sinus Disease

Other Current Health Problems

1

2

3

4

5

6

Previous Health Problems Including Surgery

1

2

3

4

5

6

MEDICATION HISTORY

Current Medications Chest Related

1		4	
2		5	
3		6	

Current Medications Not Chest Related

1		4	
2		5	
3		6	

DRUG ALLERGIES

	Name of Drug	Type of Reaction
1		
2		
3		
4		

SMOKING HISTORY

Which best describes you: ☐ Never Smoked ☐ Ex-smoker ☐ Current Smoker

If ever smoked, what age did you start? ☐

If ex-smoker, what age did you stop? ☐

If ever smoked, what was your heaviest daily intake? *(Cigs/day)* ☐

If current smoker, current daily intake? *(Cigs/day)* ☐

OCCUPATION HISTORY

What is your current occupation?

Have you been exposed to asbestos, mineral dusts, soldering, welding or toxic fumes? ☐ Yes ☐ No

If YES please provide details:

PLEASE REMEMBER TO BRING ALL OF YOUR X-RAYS, RESULTS AND ANY OTHER RELEVANT MEDICAL MATERIAL WITH YOU

Suite 49, 2nd Floor Hollywood Medical Centre – 85 Monash Avenue, Nedlands, WA 6009

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