



Patient Information for Appointment Booking

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PLEASE RETURN BY EMAIL FAX OR POST WITH A REFERRAL FROM YOUR GP OR OTHER REFERRING DOCTOR

Using the information you have provided we will assess the level of urgency of your case and then phone you to arrange a suitable time for an appointment.

Please be advised we are a private billing practice and fees are payable at the time of consultation.

Please Note: If you experience significant changes in the state of your health whilst waiting for your appointment please contact your GP or in the case of an emergency go directly to hospital.

Privacy Statement

Peninsula Gastroenterology supports the importance the community places on the maintenance of confidentiality of individuals' personal and / or sensitive information. This extends to the collection and management of information held in its records regarding individuals. However in order to provide selective services (eg pathology) information is required to be shared between trusted Medical Service Providers. By signing this consent you agree to this practice passing on your personal health information on your behalf.

Patient signature: Date:

Please sign below if you consent to receiving correspondence from this practice via email/SMS

Patient signature: Date:

Last Name: Dr / Mr / Mrs / Miss / Ms (please circle)

First Name: Middle Names:

Date of Birth: Gender: M F

Previous Names (eg maiden name): Occupation:

Address:

Suburb: State: Post Code:

Home Phone: Business Phone:

Mobile Phone: Fax:

Email Address:

Preferred contact method : (please circle) Home Business Mobile Email

Medicare #: - - - - ■ - - - - ■ - - - - Expiry Date:

Number assigned to your name on Medicare card: (single digit next to your name) -

Private Health Fund Name: Member #:

Pension Card #: Repatriation Card #:

Next of Kin Name: Relationship: Contact:

Referral Details  N.B. You must attach a copy of your referral and send it in with this form.

GP's Name:

Referring Doctors Name: (if different from GP)

Date of Referral: Referring Doctor's Phone #:

PATIENT HEALTH QUESTIONNAIRE

Do you have any allergies?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What are you allergic to? Reaction?
Have you had a faecal occult blood test positive recently?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Do you take any anti-inflammatory drugs or cortisone?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Please list under Medications below
Do you take any blood thinning drugs such as Warfarin, Asasantin, Aspirin, Plavix or Iscover?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Do you take any other medications ?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	If so, please list below or attach list
Have you been vaccinated for COVID -19? If so, how many doses 1 dose 2 doses 3 doses	No	Yes	1st dose date: 2nd dose date: 3rd dose date:
Have you had COVID -19 No Yes Date diagnosed			
Weight Kg Height cm			
NAME OF MEDICATION	DOSE		HOW OFTEN

Do you have or have you ever had any of the following conditions:

High Blood Pressure ?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How long?
Chest Pain or Angina?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How often?
Heart Attack or Coronary stent?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	When?
Pacemaker, irregular heart beat, palpitations or any other heart condition?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What type?
Do you suffer from sleep apnoea?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Shortness of breath when climbing stairs or inclines?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Shortness of breath when lying flat?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Chronic bronchitis, emphysema?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Give details
Asthma?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Requiring hospitalisation?
Diabetes?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Do you take insulin / tablets?
Epilepsy or fits?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	When was the last fit?
Stroke?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	When?
Blood clots or bleeding disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Give details
Anaemia?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What type?
Previous blood transfusion?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	When?
Stomach ulcers / Hiatus hernia /Heartburn	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Please specify
Hepatitis or liver disease?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What type?
Kidney condition ?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What type?
Arthritis?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What type?
Do or have you ever smoked?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How many per day? <input type="checkbox"/> How many years?
Do you drink alcohol?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How many per week?
Is there a condition that runs in the family?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Please specify

I have read and understood this form and filled it out accurately to the best of my knowledge. **Signed:**