NUREVA PATIENT INFORMATION

Title: Mrs/Miss/Ms ______________ First Name: ____________________

Surname: ______________________ Preferred Name:_________________

Address: ____

Date of Birth: _____________________

Phone: (h) ________________ (w) _______________ (m) ______________

Email: ____

Medicare Number: _______________________ Reference No:________

Private Health Fund: _______________________

Membership No: _______________________ Reference No: ________

Referring Doctor: ____

Usual G.P: ____

How were you referred to this practice? ☐ GP ☐ Friend ☐ Other – Please specify _____________

Occupation: ______________________________

Partner's Name: __________________________ D.O.B. ________________

Next of Kin: ______________________________ Phone: _________________

Language Spoken: _________________________

I give consent for pictures and video that may be obtained throughout my care to be used for authorised third parties, research purposes and teaching purposes

Signed: _______________________________________Date:_________________

I understand that should there be any non payment of my accounts, Nureva Women's Specialist Health may use debt collectors to recover outstanding funds and there may be an administration fee applied to this.
Signed: _______________________________________Date:_________________

PATIENT CONSENT:

I ____ give my consent for Nureva Women's Specialist Health to collect any necessary medical information on my behalf. I understand that it may be necessary for this information to be passed on to other health care providers.

Signed: ________________________________ Date: ________________________________

MEDICAL HISTORY

- Date of the first day of your last menstrual period:_______/_______/______
- Do you have a **Regular** or **Irregular** cycle?(please circle) Cycle length: _________ days
- If you are **post-menopausal**, what year did you stop having regular periods? __________
- Number of pregnancies _____________
- Mode of Last Delivery **Normal Vaginal Delivery** or **Caesarean Section** (please circle)
- What was your last **pap smear** result? **Normal** or **Abnormal** (please circle)
- Current Medical Conditions: ____

  ____
- Current Relevant Medications including: (please tick)
  - ☐ Oral Contraceptive Pill
  - ☐ IUD/ Mirena
  - ☐ Implanon
  - ☐ Depo Provera
  - ☐ HRT
  - ☐ Other ____
- Allergies ___________________________________
- Current weight _____________ Height __________________
- Are you a smoker? **Yes / No** (please circle)
- Have you had any previous surgery?____
- Have you had any recent blood tests? Date ______________ Where? __________________
- Have you had any recent ultrasounds? Date ______________ Where? __________________