DR THOMAS DEAN, FRCS, FRACS

CONSULTANT UROLOGICAL SURGEON

Mr/Mrs/Miss/Dr Date of Birth: ……

Surname:……. Given Names:…….

Address:……

Phone H: ……W: …… Mobile: ……....

Email Address: ……....

Medicare No: …… Valid to: …… Position on Card: …….

Pension No: ……. Expires: ……. Type: Age/Disability

Department of Veterans' Affairs No: ……..Gold/White

Private Health Insurance Yes/No Fund Name: ……M/Ship No: …….

What is your occupation: ……
(if retired please state your occupation prior to retirement)

Please list your previous surgical operations, with dates if possible:

Please indicate if you have ever suffered or do suffer from any of the following:

Heart disease …….High blood pressure ……. Diabetes ……. Lung disease ……

Stroke ……. Bleeding disorders ……. Hepatitis ……

Thrombosis (eg clot in leg) ……. Have you ever smoked Yes / No If yes, how many/day…….

What is your average alcohol consumption? …….

Do you have any allergies (and what happens)?……

…….

Please list all your regular medications, including any herbal preparations:

Do you take blood thinning agents such as Aspirin, Plavix or Warfarin……...

Are you or could you be HIV positive: Yes / No

Local Doctor (GP)……

Referring Doctor (if different to GP) ……

Your privacy and rights are respected under the National Privacy Act. In order to facilitate quality health care I give permission to release my medical history and details to all medical and health professionals involved in my care. I understand that my file may be used for research and teaching purposes but in an unidentifiable form. I agree to take responsibility for the timely payment of all my accounts.

Signed: …… Date: ……..