PRE CONSULTATION SHEET

This form is designed to assist the doctor by obtaining more complete information. We would be grateful if you would answer the below questions as best to your ability. (a best effort is appreciated-but do not be concerned if certain sections cannot be completed). Family history and social information are requested because these features often have an unexpected bearing on clinical problems. Thank you.

NAME:

Brief Description/symptoms:

Have symptoms changed over time?

Approximate date of onset?

Anything that makes it worse or better?

VACCINATION HISTORY: Covid-19 Shingrix Zostavax Flu

***All medications (include dosage):**

***Allergies and/or side effects from medication:**

***Past medical problems (e.g: high blood pressure, diabetes, ulcers, psoriasis, reflux etc):**

***Past operations:**

***Are you under the care of any other specialist and if yes, who?**

***Name of your local GP:**

***Is there a family history of illness (e.g diabetes, gout, Ankylosing spondylitis, iritis) ? :**

***Occupation:**

***Marital status**_____ **No. of children** _____

***Do you do regular exercise? If so, what type ?**_____

***Smoker?**(if yes how many per day)**…….Alcohol?**(if yes, how many standard drinks per week)**……..……**

Medicare Number: _____ Ref:_____ Exp:___/___

Pension Number:_____ Exp:___/___

Healthfund Provider:_____ Number:_____

Email Address:_____