North Coast Surgical Suite

Suite 14, Level 4
St Vincent's Specialist Medical Centre
20 Dalley Street
LISMORE NSW 2480
Phone 02 66218277
Fax 02 66216669

Dr Robert Simon PATIENT INFORMATION FORM

Name: _____ **D.O.B:** _____

Height: _____ (approx) **Weight:** _____ (approx)

What are you seeing the doctor for?

_____

_____

How long have you had the symptoms? _____

Have you had this condition before? **Yes ☐** **No ☐**

Do you have any of the following health problems?

- Heart disease ☐
- Kidney / Renal disease ☐
- Diabetes ☐
- Asthma / Emphysema ☐
- Blood pressure ☐
- Arthritis ☐
- Liver disease or Hepatitis A/B/C ☐
- HIV ☐

Do you have any other serious health problems?

_____

_____

List of medications and why you take them (if you know):

_____

_____

_____

_____

Are you taking any blood thinners? Yes ☐ No ☐
E.g. Aspirin, Clopidogrel, Plavix, Iscover, Warfarin, Pradaxa, Fish oil, Rivaroxaban, Xarelto, Apixaban.

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What symptoms have you had?

_____

_____

Has any of your family had the same condition as you? _____

Has any of your family had cancer? _____

If so, which cancer and at what age? _____

Do you smoke? Yes ☐ No ☐ How many per day? _____

Do you drink? Yes ☐ No ☐ How many per day? _____

Do you have any allergies? _____

Have you or your family had any reactions to Local / General Anaesthetic?

_____

_____

Ladies:

Are you pregnant? Yes ☐ No ☐

Do you have children? Yes ☐ No ☐ How many? _____

Did you have any breast-feeding problems? _____

Have you used HRT / Hormone Replacement Therapy? Yes ☐ No ☐

Have you had a Hysterectomy or your ovaries removed? _____

Have you been through the change of life / menopause? _____

_____ Date: _____
SIGNATURE – (Parent/Guardian to sign if patient is under 18 years of age)