MACQUARIE RESPIRATORY & SLEEP

MQ HEALTH RESPIRATORY & SLEEP
Macquarie University Clinic & Hospital
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NEW PATIENT DETAILS, CONSENT & QUESTIONNAIRE

Please answer the following questions as best you can. If you are uncertain about any answers, please speak to one of our team.

TITLE: _____ **FIRST NAME:** _____ **LAST NAME:** _____ **MIDDLE NAME:** _____

PREFERRED NAME: _____ **DATE OF BIRTH :** _____ **ASSIGNED GENDER AT BIRTH:** ☐ **MALE** / ☐ **FEMALE**

ADDRESS: _____

MOBILE NUMBER: _____ **LANDLINE:** _____ **EMAIL ADDRESS:** _____

MEDICARE NUMBER: _____ **REF #:** _____ **EXPIRY:** _____

ETHNICITY (required for lung function testing predicted values): _____

PRIVATE HEALTH FUND : _____ **MEMBERSHIP NUMBER :** _____

DVA NUMBER: _____ **DVA CARD COLOUR:** ☐ **GOLD** / ☐ **WHITE** *If known, specify approved treatment* _____

PENSION NUMBER: _____

EMERGENCY CONTACT, Name: _____ **Number:** _____ **Relationship:** _____

USUAL GP: _____ **GP ADDRESS:** _____

REFERRING DOCTOR: _____ **REFERRER'S ADDRESS:** _____

PLEASE READ CAREFULLY AND TICK YOUR RESPONSES:

1. Have you	**YES**	**NO**
Had surgery in the last 6 months?	☐	☐
If YES, please detail:		
2. Smoking History:	**YES**	**NO**
• A current smoker? (Vaping included)	☐	☐
• An ex-smoker? (Age started: ____ Age stopped: ____ Avg. cigarettes per day: ____	☐	☐
• Do people at home smoke? _____	☐	☐
3. Respiratory medication	**YES**	**NO**
If you are taking inhalers/puffers, have you taken your puffers today?	☐	☐
If YES, please record time and dose: _____		

4. Tick any inhalers/puffers/medication you usually take

Airomir	☐	Bricanyl	☐	Oxis	☐	Spiolto	☐
Alvesco	☐	Brimica	☐	Pulmicort	☐	Spiriva	☐
Anoro	☐	Flixotide	☐	Respocort	☐	Symbicort	☐
Asmol	☐	Fluticasone	☐	Respolin	☐	Tilade	☐
Atrovent	☐	Flutiform	☐	QVAR	☐	Trelegy	☐
Becloforte	☐	Fostair	☐	Seebri	☐	Trimbow	☐
Becotide	☐	Incruse	☐	Seretide	☐	Ultibro	☐
Breo	☐	Intal	☐	Serevent	☐	Ventolin	☐
Bretaris	☐	Onbrez	☐	Singulair	☐	Other:	

CONSENT:

I am fully aware of any fees/charges for consultations/tests performed.
I hereby give consent to the release of necessary medical documentation being requested by medical practitioners, hospitals, departments, or ancillary practices such as pathology, radiology.
I give permission to receive SMS/email appointments confirmations.
I give permission to contact my emergency contact in the event of any emergency/if unable to contact patient.

Please tick box ☐ to authorise access to your My Health Records

NAME: _____ **SIGN:** _____ **DATE:** _____

Our practice complies with the Australian Privacy Act – for further information visit www.privacy.gov.au

MEDICAL HISTORY:

WHAT OPERATIONS HAVE YOU HAD: Please list

MEDICATIONS: Please include dosage and frequency

ALLERGIES, IF KNOWN:

ILLNESSES, IF KNOWN:

ALCOHOL HISTORY:

- **Never drink alcohol** ☐
- **Average daily consumption:** ☐ **Age when started drinking:** ☐ **Age when stopped drinking:** ☐

ENVIRONMENTAL EXPOSURES:

- **Are you exposed to birds at home?** ☐
- **What pets do you have?** ☐
- **Have you been exposed to asbestos?** ☐
- **Have you been exposed to silica?** ☐
- **Any other known exposures?** ☐
- **What is your occupation?** ☐

FAMILY HISTORY: *If known, include age and illness of living/deceased immediate family members (parents, siblings, children)*

Father *(living/deceased)* ☐ ☐ Age: ☐ Illness/es: ☐

Mother *(living/deceased)* ☐ ☐ Age: ☐ Illness/es: ☐

Siblings *(living/deceased)* ☐ ☐ Age/s: ☐ Illness/es: ☐

☐ Age/s: ☐ Illness/es: ☐

Children *(living/deceased)* ☐ ☐ Age/s: ☐ Illness/es: ☐

☐ Age/s: ☐ Illness/es: ☐