**Dr Y Rajapakse Plastic and Reconstructive Surgeon**

**PATIENT INFORMATION Cont.**

**Referring Doctor:………………………. Name of GP if different……………………**

**Private Health Fund……………………. Membership No………………………………**

**Veteran Affair No…………………………**

**Occupation………………………………….. Employer………………………………………..**

**HOW DID YOU FIRST HEAR ABOUT US (**please circle)

**Family/Friend………………………………. GP Specialist**

**ASPS Internet Website**

**Yellow pages Other………………………………………**

**HEALTH QUESTIONNAIRE**

**Height……….. Weight……… Daily Intake Smoking…….. Intake Alcohol…….**

**Any Significant medical problems…………………………………………………………**

**Past use of steroids/cortisone………………………………………………………………**

**Past operations (include cosmetic surgery)………………………………………….**

**Are you allergic to medicines?…………….............. …………Dressings?..............**

**Past/ family history of bleeding?...........................................................................**

**Past / family history with anaesthesia** (general/local)**?......................................**

**Regular Medications (include Aspirin)………………………………………………..**

**Are you taking any blood thinner/s regularly?** If yes please circle

Aspirin Warfarin NSAIDs Plavix Asasantin

Fish oil Other……………….

**Do you have a history of the following?** (please circle)

Asthma Rheumatic Fever Contact lens Cold Sores

Diabetes Blood Clots Psychiatric Treatment Healing Problems

Spinal/ Neck problems Arthritis Keloid Scars Wound Infection

Heart Conditions High Blood pressure Hepatitis HIV/AIDS exposure

**CONSENT**

**I give permission for clinical photographs to be taken as part of my consultation YES/NO**

**My clinical photographs may be used for medical education purposes YES/NO**

(doctors , nurses, medical students)

**My clinical photographs may be used for public education purposes YES/NO**

**My consultation notes may be used in communication with other hearlth professionals involved in my care YES/NO**

**I would like to receive information and special offers from time to time YES/NO**

**PATIENT/GUARDIAN SIGNATURE…………………………………………… DATE………..**