SPECIALIST VASCULAR CLINIC

Dr Walid Mohabbat
MB BS (Sydney) FRACS (Vascular)
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PATIENT REGISTRATION and HISTORY FORM

TITLE: **Mr / Mrs / Ms / Other ..... (please circle)**

SURNAME: _____ D O B **:** _____

GIVEN NAMES: _____

ADDRESS: _____

SUBURB: _____ STATE:_____ POSTCODE:_____

TEL: (Home) _____ (Work) _____ (Mob) _____

EMAIL:.....

MEDICARE NUMBER: _ _ _ _ _ _ _ _ _ _ _ PATIENT ID number: ____ EXP : __/__

PENSION or DVA Number ..... EXP DATE ...../...../.....

HEALTH FUND ..... MEMBERSHIP NUMBER .....

Does your insurance cover you for Private Hospital admission? .....

Are you a WORKCOVER Patient? _____ Please provide WORKCOVER details _____

_____

REFERRING DOCTOR : Name & Address: .....

.....

Family Doctor (if different to referring doctor).....

MEDICAL HISTORY

Do you have a past medical history of any of the following? (tick)

Hypertension (High blood pressure)_____ Previous Heart Attack: _____

Hypercholesterolaemia (High cholesterol) _____ Diabetes _____

Stroke _____ Asthma _____

Deep Vein thrombosis _____ Varicose Veins _____

Family history of vascular disease_____ Please give details _____

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SOCIAL HISTORY

SMOKING Never smoked_____ Ex smoker _____ When did you cease _____

Still smoking _____ Number of cigarettes daily _____

ALCOHOL intake: Nil _____ Occasional _____ Weekly _____ Daily _____

CURRENT MEDICATIONS

Aspirin _____ Warfarin _____ DOSE _____

Other medications:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies _____

PREVIOUS OPERATIONS (Major)

Operations	Year	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIVACY STATEMENT

To comply with the Privacy Act 2001, all patients need to provide written consent for the following important aspects of their medical care.

- **I agree that Dr Mohabbat takes a full medical history that relates to my medical condition and management.**
- **I agree that relevant information may be obtained from other medical practitioners, such as GP's and specialists, other health care providers , pathologists, hospital and Day Surgery Units as necessary.**
- **I agree that Dr Mohabbat may discuss my medical history, diagnosis and management with my General Practitioner and other relevant Medical Specialists in relation to my medical management.**
- **I understand that I may apply to access my health records.**

PATIENT NAME.....

PATIENT'S SIGNATURE..... DATE .....