CancerMelbourne
with Oncology Specialists of Melbourne

Patient Details

Patient Name:

Title: Mr / Mrs / Miss / Ms First Name: _____ Surname: _____

Preferred Name: _____

Address: _____

Suburb: _____ Postcode: _____

Mobile: _____ Phone (Work): _____

Phone (Home): _____ Email: _____

Date of Birth: _____ Age: _____

Occupation: _____

Relatives:

Name: _____ Name: _____

Address: _____ Address: _____

Phone (Home): _____ Phone (Home): _____

Phone (Work): _____ Phone (Work): _____

Relationship to Patient: _____ Relationship to Patient: _____

Referral Details:

Which Doctor referred you? _____

Who are the other doctors involved in your care? (eg: Family Doctor) _____

_____

Account Details:

Medicare No: _____ Card Ref No: _____ Expires: _____

Do you have Private Health Insurance? Yes / No
(eg: Medibnk, HBA)

Health Fund Name: _____

Membership No: _____

Level of Cover: _____

Date Joined: _____

Account Details:

Is this illness through Work Cover? Yes / No Insurance Claim No: _____

Name of Insurer: _____

Are you covered by Veterans Affairs? Yes / No Veteran No: _____

Card Type: White Card / Gold Card

Medical Details:

What are you current medications?

Name:	Strength:	How many Per Day:

Have you had any past illnesses? If so, since when

Diabetes :	Yes / No	
TB:	Yes / No	
Asthma:	Yes / No	
Rheumatic Fever:	Yes / No	
Heart Attacks:	Yes / No	
Blood Pressure:	Yes / No	
Smoke:	Yes / No	How many per day?

Are you allergic to any medications?

Penicillin:	Yes / No
Sulphur Drugs:	Yes / No
Other:	

Are you on warfarin?	Yes / No
Are you on plavex?	Yes / No
Are you on aspirin?	Yes / No

What is your approximate height? (cm) _____

Have you had surgery in the past?

Operation Type:	When (Approx):	By Whom:

I allow Dr to discuss my condition and treatment with other appropriate health care professionals.

Signature: _____ Date: _____