Ms KAREN BARCLAY

COLORECTAL AND GENERAL SURGEON

MBChB, BMedSci, FRACS, CSSANZ, G Cert Clinical Ultrasound

Combining compassion with surgical expertise…



Name: _____

Preferred Name: _____

Birth Gender: Male Female

Preferred Pronouns: He/Him
She/Her
They/Them

Date of Birth: _____

Country of Birth: _____

Preferred language: _____

Address: _____

_____

Phone: _____

Email: _____

Medicare card: _____

Individual reference: _____

Expiry: _____

Private Health Insurance: ☐ Yes ☐ No

Insurer: _____

Card number: _____

Hospital Extras Overseas

Next of kin:

Name: _____

Phone: _____

GP:

Name: _____

Practice: _____

Address: _____

Height _____ Weight _____

Do you have any of the following? If yes, please tick the box:

- ☐ Heart murmur or valve disease
- ☐ Irregular heart beat or AF
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Previous heart attack or angina
- ☐ Anemia
- ☐ Iron deficiency
- ☐ Abnormal blood clotting
- ☐ Diabetes - Type 1 Type 2
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Obstructive sleep apnoea
- ☐ Snoring
- ☐ Previous stroke
- ☐ Epilepsy or seizures
- ☐ Chronic fatigue or MS
- ☐ Impaired kidney function
- ☐ Impaired liver function
- ☐ Heartburn or reflux
- ☐ Crohn's disease or UC
- ☐ Unexplained weight loss
- ☐ Previous cancer
- ☐ Thyroid condition
- ☐ Arthritis
- ☐ Difficulty hearing
- ☐ Visual impairment
- ☐ Intellectual impairment
- ☐ Impaired mobility
- ☐ Depression
- ☐ Anxiety
- ☐ Other

Have you ever had surgery? ☐ Yes ☐ No If yes, please list:

_____

Have you been hospitalized for non-surgical conditions? ☐ Yes ☐ No If yes, what for?

_____

Do you have drug allergies? ☐ Yes ☐ No If yes, please list drug and reaction: _____

Please turn over.....

Do you take prescribed medications? ☐Yes ☐No If yes, please list: _____

_____

_____

Do you take herbal treatments or supplements? ☐Yes ☐No If yes, please list: _____

_____

_____

Do you currently smoke or chew tobacco? ☐Yes ☐No If yes, how many packs per day?

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks in a usual week?

Do you live alone? ☐Yes ☐No

Can you walk up a flight of stairs comfortably? ☐Yes ☐No

Do you exercise regularly? ☐Yes ☐No

Do you usually work outside of the home? ☐Yes ☐No If yes, what is your occupation?

Family history:

	Living	Age (or age at death)	List serious illnesses
Mother	☐Yes ☐No	_____	_____
Father	☐Yes ☐No	_____	_____
Sisters	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
Brothers	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____

Grandparents:

Maternal	Grandmother	_____	Grandfather	_____
Paternal	Grandmother	_____	Grandfather	_____

Do you have an Advanced Care Directive? ☐Yes ☐No

Do you have a Medical Power of Attorney? ☐Yes ☐No

Other important information:

IMPORTANT - Please read and ask questions if needed. In signing this document you confirm:

The information on this form is complete and accurate to your best knowledge.
You are aware AI protected to health-information standards may be used to assist documentation.

Information will be uploaded to your MyHealth Record.

You consent to transfer of information between health professionals directly involved in your care.
You consent to electronic or email communication, with the knowledge that as with any form of communication, complete security cannot be guaranteed.

You have had the opportunity to read the Fees Schedule.

You consent to Medicare Benefit Assignment to Ms Barclay or relevant provider for Claims for Bulk Billing, Procedures & Investigations.
You consent to information use for audit, quality assurance and de-identified research.

Patient/Guardian Signature_____ **Date** _____

FRACS Fellow of the Royal Australasian College of Surgeons MEMBER CSSANZ GESA Gastroenterological Society of Australia