DR TRACEY LAM
Endocrine and General Surgeon

Suite 6.5, 89 Bridge Road
Richmond 3121

76 Edwin Street
Heidelberg Heights 3081

P 03 9249 1002
F 03 8672 0771

New Patient Registration Form

Title: _________ First Name: ________________________ Surname: ____________________________________

Preferred Name: ___________________________________ DOB: _____/_____/_____ Sex: ______________

Address: ____

Home Phone: ____________________________ Mobile: ____

Occupation: _____________________________ Email: ____

I agree for medical correspondence to be sent via my email : YES / NO *(please circle)*

Next of Kin: _____________________________ Phone: _____________________ Relationship: _______________

Local Doctor (GP) & Name of Clinic: ____

Address: ____

Referring Doctor (*if different*) ____

Address: ____

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No: _____ Exp Date: _______ / _______

Private Hospital Insurance: YES / NO If YES; longer than 12 months YES / NO

Fund Name: _________________________________ Number: ___________________ Level of Cover _________

Veterans Affairs (DVA) Number: _____________________________________ GOLD / WHITE *(please circle)*

Motor Accident ? -TAC Number: ________________________________ Date of Accident: _________________

Workcover: Name of Employer: ____

Address of Employer: ____

Telephone Number: ________________________________ Claim No: ___________________________________

Name & Address of Insurance Company: ____

I give my consent for Dr Tracey Lam to use my information to communicate with other health professionals. I also give consent to Dr Tracey Lam obtaining relevant information about myself from other health professionals. Dr Lam may order investigations with Radiology/Imaging such as: MRI, CT, ultrasound scans & pathology. These investigations may incur fees and you should ask at the time of booking what the cost to you will be.

Signed: ____ **Date:** _____ / ______ / ______

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Patient Health Survey

Name: ____ DOB: _____/_____/_____

Weight: ______________ kg Height: ______________ cm

Main diagnosis/symptoms (brief): ____

____

Past medical/surgical problems: ____

____

____

Do you take any **blood thinning medications**: YES / NO *(List name & dose of medication below)*

Medications: prescribed and non-prescribed (*OR please attach a list)*

Name	Dose	Name	Dose

Allergies: *(medicines/tapes/antiseptics/foods/latex/rubber)* ______________________________

Smoker? Yes / No / Ex-smoker

Details *(current or previous)*: Duration of smoking: __________________ Cigarettes / day: _____________

Alcohol – std drinks / week: ___________________ Recreational drugs: No_____ Yes ______________________

General Medical Conditions *(current and previous)*
Please circle any conditions/symptoms you have and provide details

Hearing impairment	Yes / No	Heart attack	Yes / No	Asthma	Yes / No
Visual impairment	Yes / No	Angina	Yes / No	Bronchitis/Emphysema	Yes / No
High blood pressure	Yes / No	Heart surgery	Yes / No	Pneumonia	Yes / No
High cholesterol	Yes / No	Coronary stent	Yes / No	Tuberculosis	Yes / No
Diabetes	Yes / No	Palpitations	Yes / No	Sleep apnoea	Yes / No
If yes - Type 1 or Type 2		Pacemaker	Yes / No	Breathing difficulties	Yes / No
If yes - diet / tablets / insulin					
Thyroid disorders	Yes / No	Kidney disease	Yes / No	Anaemia	Yes / No
Stroke/TIA	Yes / No	Prostate disease	Yes / No	Bleeding disorders	Yes / No
Epilepsy/Seizures	Yes / No	Liver disease	Yes / No	Clotting disorders	Yes / No
Details:		Details:		Details:	

Signed: ____ Date: _____ / _____ / _____