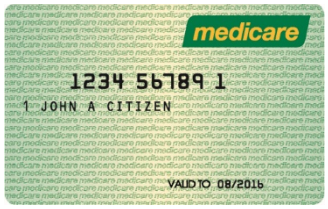
# Dr Piksi Singh

**Gynaecological Oncologist, MBBS, FRANZCOG, CGO.**

## Patient Information Sheet

**Mrs, Ms, Miss ,Dr (Please circle one)**
**First Name_____Surname _____DOB___/___/___**
**Person responsible for account:_____**
**Full Address: _____**
**Postal Address (if different):_____**
**Phone: Home_____Work_____ Mobile_____**
**Email --_____@_____**
**Occupation_____**
**Private Health Fund: _____ Membership #_____**
**Medicare Number:_____ Reference:____ Expiry: _____**




**HEIGHT:**

**WEIGHT:**

**Next of Kin/Emergency Contact Name:_____**
**Relationship:_____ Phone:_____**

**Do you suffer/ have any of the following If yes please give details/Medications**

| | | | |
|---|---|---|---|
| 1) | Females are you pregnant | Yes/No | _____ |
| 2) | Heart murmur/disease | Yes/No | _____ |
| 3) | Pacemaker | Yes/No | _____ |
| 4) | High Blood Pressure | Yes/No | _____ |
| 5) | Blood disease/bleeding disorder | Yes/No | _____ |
| 6) | Radiation treatment | Yes/No | _____ |
| 7) | Rheumatic fever? | Yes/No | _____ |
| 8) | Thyroid | Yes/No | _____ |
| 9) | Epilepsy | Yes/No | _____ |
| 10) | Diabetes | Yes/No | _____ |
| 11) | HIV/Aids | Yes/No | _____ |
| 12) | Hepatitis | Yes/No | _____ |
| 13) | Liver or Kidney disease | Yes/No | _____ |
| 14) | Respiratory problems | Yes/No | _____ |
| 15) | Low Blood Pressure | Yes/No | _____ |
| 16) | Nervous disorder | Yes/No | _____ |

**17) Osteoporosis** **Yes/No** **_____**
**18) Depression/Anxiety** **Yes/No** **_____**
**19) Other** **Yes/No** **_____**

**Do you take aspirin, Plavix, Warfarin, Clexane injection, heparin injection or any other blood thinning medication? Yes/No _____**
**_____**

**Do you take any herbal/natural medications or supplements? Yes/No _____**
**_____**

**Are you ALLERGIC to any latex products, medications or treatments? Yes/No_____**
**_____**

**Have you had any Previous Surgery/Operation**
**Yes/No_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**

**<u>G.P. / family doctor Details</u>**
**Name: _____**
**Practice Name & Address: _____**
**_____**

**I hereby attest the information I have provided on this form to be true and accurate, I understand that this is a private practice and agree to provide payment by cash, EFTPOS, Visa or Mastercard on the day of service/treatment.**

**Name: _____**
**Signature: _____Date: _____**