Dr. SULMAN AHMED MBBS (syd.) MS (syd.) FRACS ☐

PATIENT INFORMATION SHEET

Name……...

Date of birth:…….Country of birth……

Medicare No……..…..……Exp…..…….Reference……..(left side of name)

Address……...

Email…… Phone/Mobile…….……..……. .

Local GP ……..…

Health Fund……Member No.……..

PAST MEDICAL HISTORY- What medical problems do you have?

☐ Cancer ☐ Heart Disease ☐ Stroke
☐ Diabetes ☐ Lung Disease ☐ Other……

Do you smoke? ❑ Yes ❑ No If yes, how many? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much? _____

List all operations / procedures that you have had and when they were performed:

Surgery/Procedure:	**Surgeon:**	**Date:**

Family Medical History-Mother/Father/siblings etc

……

…….

Allergies……

Circle any of these medications if you take them: **Aspirin/Warfarin/Iscover/Plavix/Clopidogrel**:

Other Medications including birth control pills and vitamins:

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Please note:

- **Due to Privacy Laws you are required to agree that we can report back to your GP and other doctors (if required) about your medical health.**

- **If you require an operation you may elect to be a public or private patient.**

- **If you are a *PUBLIC PATIENT*, then any doctor who is training to be a specialist will perform the operation and you will be placed on the waiting list which can be up to a year.**

- **If you are a *PRIVATE PATIENT*, the operation will be performed by Dr Sulman Ahmed in a PRIVATE hospital, an operation date will be given and you will be given a quote of the costs involved.**

- **If you do not have *PRIVATE HEALTH INSURANCE* but elect to be a self-funded *PRIVATE PATIENT* in a *PRIVATE hospital*, we can provide a quote for the costs involved and Dr Ahmed will perform the surgery and an operation date will be given.**

- **If you do not have *PRIVATE HEALTH INSURANCE* but you elect to be a self-funded *PRIVATE PATIENT* in a *PUBLIC* hospital, we can provide a quote for the fees and Dr Ahmed will perform the surgery, however you will be placed on the PUBLIC wait list. Unfortunately, no operation date will be given.**

I hereby give authority for my medical records to be forwarded to other medical practitioners and allied health professionals in relation to my medical condition.

Signature ……Date……....

NAME……..