SPECIALIST MEDICINE
TOOWOOMBA

Dr Manuprabha Ratnayake MBBS(Melb), FRACP
St Andrew's Hospital
280 North Street. Suite 20 East Wing TOOWOOMBA QLD 4350

T: 07 4633 0999 F: 07 4633 0027

Patient Information

Title: MR MRS MS MISS MASTER OTHER _____ (please circle)
First Name:_____ **Surname:**_____ **Middle Name:**_____
Known As:_____ **Maiden Name:**_____ **DOB**:_____
Residential Address:_____
Suburb:_____ **State:**_____ **Post Code:**_____
Phone: H_____ **W**_____ **M**_____
Postal Address: (if not as above)_____

Country of Birth:_____ **Primary Language:**_____
Origin: Aboriginal TSI Neither (please circle) **Occupation:**_____

Medicare No:_____ **Ref. No:**____ **Expiry Date:**_____
Health Fund Name:_____ **Member No:**_____ **Ref. No:**____
DVA No:_____ Gold Card/White Card Condition_____
Referring GP:_____ Address:_____
Usual GP: (if not referring Doctor)_____ Address:_____

Medical History: High/Low Blood Pressure Heart Attack Angina Asthma Heart Surgery Cardiac Stent Stroke/TIA Diabetes Migraines Chronic Infection DVT/PE Notifiable Disease Other **Please provide details and dates**

_____

_____

Medication List: **Please include vitamins and herbal medications**

Medication	Dose	Frequency	Medication	Dose	Frequency
1			6		
2			7		
3			8		
4			9		
5			10		

Allergies:_____
Previous Surgery:_____

_____

Previous Tests: XRAY CT MRI U/S Pathology Echocardiogram Myocardial Perfusion Test Hearing Vision Other **Please provide details and dates**

_____

_____

Are you Diabetic? NO YES TYPE I TYPE II Year diagnosed_____
Smoker: **Never Ex-smoker Socially Weekly Daily** No. of cigarettes_____
Alcohol Intake: **Never Socially Weekly Daily** No. of standard drinks_____

Next of Kin:_____ **Relationship:**_____
Address:_____
Phone: H_____ **W**_____ **M**_____
Emergency Contact:_____ **Relationship:**_____
Address:_____
Phone:H_____ **W**_____ **M**_____

Patient Name:_____ **Patient Signature:**_____ **Date:**_____
Gaurdian Name:_____ **Gaurdian Signature:**_____ **Date:**_____