Northside Dermatology

Dr Wenyuan Liu MbChB PhD FACD
Dermatologist & Dermatologic surgeon
Provider 243379DB

PATIENT DETAILS

Mr/Mrs/Ms/Miss/Other_____ _____

Title (Please circle one) First Name Surname

Address:

_____ Home Phone:_____

Suburb:_____ Work Phone:_____

State:_____ Postcode:_____ Mobile:_____

Date of birth:_____ Email: _____

Do you agree to receive SMS text messages in relation to your medical care and as an appointment reminder? ◯ YES ◯ NO

Medicare No.: _____ Number on Card: _____ Expiry:_____

Do you have Private Health Insurance? ◯ YES ◯ NO Name of Fund: _____

Membership No. _____ Card Reference No._____

Do you have a Heath Care Card? ◯ YES ◯ NO Number : _____ Expiry : _____
Do you have a Pension Card? ◯ YES ◯ NO Number : _____ Expiry :_____
Do you have a DVA Card? ◯ YES ◯ NO Number: _____ Expiry:_____
◯ WHITE ◯ GOLD

DETAILS OF YOUR HEALTH CARE PROFESSIONALS

Name of Regular GP:_____
Name of Practice:_____
Address:_____
Phone Numbers: _____

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP?
If so, please list then:
Name: Address: Phone:

_____

_____

DETAILS OF NEXT OF KIN

Name: _____ Relationship to Patient :_____Best Contact Number:_____

FURTHER INFORMATION

Would you like to be placed on our email list to receive our newsletter? ◯ YES ◯ NO

PRIVACY STATEMENT & MEDICAL PHOTOGRAPHY

We take your personal & medical privacy seriously and in accordance with the Australian Privacy Principles of the Privacy Amendment Act 2012. Your information is not disclosed to any third party unless a written signed authority is provided by you or if requires by law. Correspondence is almost always sent back to the referring general practitioner. In some circumstances, your medical information may be disclosed to other treating doctors or a health authority if there is a clear benefit to the health and wellbeing of yourself or the public. Medical photography is utilised for the reference & documentation of your condition. At times, your photographs may be used for teaching in a way that does not reveal your identity. By signing below, you understand and consent to your information & photographs to be collected & used as described above by Northside Dermatology.

YOUR SIGNATURE: _____ DATE:_____

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PATIENT HEALTH QUESTIONNAIRE

Please list your current medications (Please include any Vitamins, Pills & any other over the counter supplements that you take)

_____
_____
_____

Do you have any allergies to any medications? ◯ YES ◯ NO
If Yes, Please list

_____
_____

FOR FEMALES

Are you, or could you be pregnant? ◯ YES ◯ NO
Are you planning or becoming pregnant in the immediate future? ◯ YES ◯ NO

SKIN CANCER RISK ASSESSMENT (All patients to complete regardless of current problems)

Have you ever had skin cancer? ◯ YES ◯ NO
(If yes, please provide further details)

Has anyone in your family ever had a Melanoma? ◯ YES ◯ NO
How many blistering sunburns do you think you may have had in your lifetime? _____
How would you rate your sun-protective behaviour? ◯ POOR ◯ GOOD ◯ EXCELLENT

SURGICAL ASSESSMENT (ALL patients need to complete this section regardless of current problem)

Do you have a pacemaker or defibrillator? ◯ YES ◯ NO
Do you have an artificial heart valve, heart murmur or artificial joint? ◯ YES ◯ NO
Do you require antibiotics prior to any procedure? ◯ YES ◯ NO
Do you have a history or family history of Keloid Scarring? ◯ YES ◯ NO
Do you have any problems with bleeding? ◯ YES ◯ NO
Are you a Smoker? ◯ YES ◯ NO

SKIN HISTORY (ALL patients need to complete this section regardless of current problem)

Do you have a history of ◯ ECZEMA ◯ ASTHMA ◯ OR HAYFEVER ?
Do you have any allergies or intolerances to Cream, Fragrances, Tapes, Jewellery/Nickle? ◯ YES ◯ NO
Does anyone in your family have Eczema, Asthma or Hayfever? ◯ YES ◯ NO
Does anyone in your family have Psoriasis or Psoriatic Arthritis? ◯ YES ◯ NO
Does anyone in your family have an autoimmune problem such as Lupus, Alopecia Areata, Vitiligo, Rheumatoid Arthritis or Autoimmune Thyroid Disease ◯ YES ◯ NO

OTHER MEDICAL HISTORY

Please list any other medical problems you may have:

Have you ever needed to see a specialist or had surgery? ◯ YES ◯ NO
If YES, Please provide more information you think is relevant regarding your health.

SIGNATURE : DATE: