HUNTER PLASTIC SURGERY
Experts in Aesthetics

DR NICHOLAS MONCRIEFF Provider No 232114XH
COSMETIC PLASTIC SURGEON
MBBS (Hons), BSC (Med), FRACS (Plast Surg)

SUITE 8, LEVEL 2, 3 HOPETOUN ST (PO BOX 83), CHARLESTOWN NSW 2290
T 02 4920 7700 **F** 02 4920 7799 **E** admin@hunterplasticsurgery.com.au
www.hunterplasticsurgery.com.au

MEDICAL HISTORY FORM – COSMETIC PATIENT

Welcome to Hunter Plastic Surgery. Please complete this form in preparation for your consultation.

Full Name: ____ **Title:**__________________

Date of Birth: __________________________ **Occupation:** ________________________________

Postal Address and post code: ____

Email address: ____ **(used for correspondence only)**

Who is your regular GP? ____

How did you hear about Hunter Plastic Surgery? ____

Which numbers may we call you on regarding results, recalls or to change an appointment?

Telephone numbers: (mobile) ___________________ (home) ___________________________

Can we leave messages for you identifying the surgery as the caller? YES NO

I authorise the following person to take messages on the provided numbers regarding reminder or change of appointment:

Nominated Person/ Next of Kin _________________________ **Relationship**: ______________________

Alternative contact number for next of kin: ____________________________

Memberships

Health fund: ___________________________ **Membership number:** __________________

Medicare number: _____________________________________**Exp date:** ___________**Number on card (1-6)**______

Medical conditions and treatment

Do you have any of the medical conditions listed below? Please select YES or NO.

Y	N		Y	N		Y	N	
		ANGINA (heart pain)			**RESPIRATORY ILLNESS** (lung problems)			**CANCER**
		HYPERTENSION (high blood pressure)			**BLEEDING DISORDER**			**CHICKEN POX** or **SHINGLES**
		DIABETES (high blood sugar)			**HEPATITIS** (liver virus or disease)			**RECENT VIRAL ILLNESS** (flu like)
		RENAL DISEASE (kidney disease)			**HIV/AIDS**			

If you answered YES for any of the above, please describe your treatment.

____

Have you experienced any of the medical issues listed below? Please select YES or NO.

Y	N		Y	N	
		DEEP VEIN THROMBOSIS (blood clots in the leg)			**DIFFICULTIES WITH ANAESTHESIA**
		PULMONARY EMBOLISM (blood clots in the lung)			**INFECTIONS** (such as MSRA)
		HEART ATTACKS			

Height: __________________ cms **Weight:** __________________ kgs

If you answered YES for any of the above, please provide details and treatment.

____

Please list any major operations you have had.

____

Did you suffer any major complications from past operations?

____

If you have a condition not listed above, please describe.

____

Medications

Which medications are you currently taking (prescription, over the counter or herbal)? Please take special care to list any blood thinners such as aspirin, Warfarin and fish oil.

____

Are you allergic to any medications? YES NO

If YES, please specify____

Habits

Alcohol: Never OR average number of drinks each day________

Smoking: Never OR average number each day________

OR if you quit in the last 5 years, when did this happen? ________

Expectations

At Hunter Plastic Surgery we pride ourselves on making our patients "healthy and happy" by attempting to meet their surgical expectations. As such, may we ask you to share your expectations with us by taking some time to answer the following questions which will be discussed during your consultation.

What concerns about your appearance have brought you to Hunter Plastic Surgery?

____

What is it that you are hoping to achieve with surgery?

____

Thank you for taking the time to share your thoughts and Dr Moncrieff looks forward to working through these during your appointment.

Agreement and signature

Privacy agreement - In order to comply with the Privacy Laws (Privacy Act Amendments – Private Sector – Act 2000) your agreement to the following statement is required:

I agree to allow Dr Moncrieff access to all relevant information regarding my medical conditions. I understand that Dr Moncrieff may be required to forward information about my medical condition or history to other health care providers. I understand that to provide the highest medical care, my clinical records may be accessed or reviewed by staff in this practice.

Use of email – I agree to the use of my email address for correspondence relating to Hunter Plastic Surgery including marketing material. Hunter Plastic Surgery will never provide these details to third parties and I can unsubscribe at any time. YES NO

Payment policy – I understand that if I proceed with a surgical procedure that all payments are required 14 days before the operation or the surgery will be cancelled.

Photograph policy – All cosmetic patients have before and after photos taken which are kept with your records. On some occasions, Dr Moncrieff will use these photos, with reasonable identity protection, for educational or marketing purposes. If you would prefer your photos not to be used in this way, please tick this box. OPT OUT

Signed: .... Date: .... (Please sign manually after printing)

Please print and sign your form on completion. If you have a scanner, you can return to us via email to admin@hunterplasticsurgery.com.au, otherwise simply bring your form with you to your consultation.