Dr Benjamin Bopp

Patient Information Sheet

Reason for Referral: ❑ Pregnancy ❑ Gynaecology ❑Fertility ❑ Pap Smear

Have you attended this practice before? ❑ Yes ❑ No *(Please fill in your personal details below)*

PERSONAL DETAILS *(Only complete if you answered No to the above question)*

Name: ..... **Middle Name:** .....

Surname: ..... **Date of Birth:** .....

Occupation: .....

Who is your referring GP? .....

CONTACT DETAILS *(Please update is these have changed since your last visit)*

Home Address: .....

.....

Postal Address: *(If different to your home address)* .....

.....

Home Phone: ..... **Mobile:** .....

Work Phone: ..... **Email:** .....

Your Partner/Next Of Kin's Name: .....

Relationship: ..... **Contact Number:** .....

Nominated Person: *(Who can ring on your behalf for results)* .....

Relationship: .....

Medicare Card Number: ..... **Reference Number:** ..... **Expiry:** .....

Health Fund: ..... **Member Number:** .....

Level of Cover: ❑ Full ❑ Extras Only

Department of Veteran's Affairs Number: .....

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MEDICAL HISTORY

When was your last pap smear? .....

Have you had any abnormal pap smears? ❑ Yes ❑ No

Have you had any recent blood tests? ❑ Yes ❑ No

If yes, on what date: ..... **Which Pathology Company?** .....

Have you had any recent ultrasounds, X-rays or CT scans? ❑ Yes ❑ No

If yes, on what date? ..... **Which Radiology Company?** .....

Please list any medical conditions: .....

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.....

Please list any prior surgical procedures: .....

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Please list any previous pregnancies: .....

.....

Please list any significant family history: .....

.....

Please list any allergies you have: .....

.....

Please list any medications your are taking: .....

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DISCLAIMER

Dr Bopp requires your information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. By signing this form and submitting this information to Dr Bopp, I authorise Dr Bopp to use my information in accordance with the Health Privacy Act and to disclose my health information to my referring GP, specialists and medical testing institutions who require my medical history to treat the particular condition/s.

I have read and understood the reasons why my information must be collected and I am aware of Dr Bopp's privacy policy on handling patient information.

I consent to examination and understand that this appointment may involve pelvic, vaginal examination and/or trans-vaginal ultrasound.

Signed: ..... **Date:** .....