EXERCISE PHYSIOLOGY SOUTH

ADDRESS: 3/3 Commerce Cres
PHONE: 0455 335 655
FAX: 08 8312 3155
EMAIL: info@epsouth.com.au
WEB: www.epsouth.com.au

PATIENT INFORMATION

Full Name			
Date of Birth			
Residential Address			
Postal Address			
Home Phone		**Mobile**	
Email Address			
Occupation			
Medicare No.		**Expiry Date**	
DVA No. **Gold / White** (please circle)		**Expiry Date**	
Concession Card No.		**Expiry Date**	
Private Health Member No.		**Fund Name**	
Next of Kin (Name)			
Relationship to patient			
Phone Number			
Do you identify as Aboriginal			**Yes / No**
Do you identify as Torres Strait Islander			**Yes / No**
Do you consent to SMS contact / reminders from us?			**Yes / No**
Do you consent to photographs of you being used to promote this organisation?			**Yes / No**

HEALTH INFORMATION

Have you been diagnosed with heart disease?			**Yes / No**
Do you take medication for heart disease?			Yes / No
Have you been diagnosed with lung disease?			**Yes / No**
Medication?			Yes / No
Have you been diagnosed with Type 2 Diabetes Mellitus?			**Yes / No**
Medication?			Yes / No
Have you been diagnosed with high blood pressure (Hypertension)?			**Yes / No**
Medication?			Yes / No
Have you been diagnosed with high cholesterol?			**Yes / No**
Medication?			Yes / No
Have you suffered a stroke or TIA?			**Yes / No**
Medication?			Yes / No
Have you been diagnosed with dementia or similar?			**Yes / No**
Medication?			Yes / No
Do you have osteopenia or osteoporosis?			**Yes / No**
Medication?			Yes / No
Have you had any joint surgery or replacement?			**Yes / No**
Brief details:			
Do you take any other medications?			**Yes / No**
Do you smoke?	**Yes / No**	**How many per day?**	
Do you drink alcohol?	**Yes / No**	**How much per day?**	

Please bring this completed form to your appointment if possible. Form can be emailed or faxed to the number / email address above prior to appointment if preferred.