SPECIALIST VASCULAR CLINIC
world class care

Dr Walid Mohabbat
MB BS (Sydney) FRACS (Vascular)
Provider No. 223629FW

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PATIENT REGISTRATION and HISTORY FORM

TITLE: .....

SURNAME: ..... D O B :.....

GIVEN NAMES: .....

ADDRESS: .....

SUBURB: ..... STATE: ..... POSTCODE: .....

TEL: (Home) ..... (Work) ..... (Mob) .....

MEDICARE NUMBER: _ _ _ _ _ _ _ _ _ _ _ PATIENT ID number: ____ EXP DATE: __/__

PENSION / VET AFFAIRS Number .....

HEALTH FUND ..... MEMBERSHIP NUMBER .....

Does your insurance cover you for Private Hospital admission? .....

REFERRING DOCTOR: Name & Address: .....

.....

Family Doctor (if different to referring doctor).....

MEDICAL HISTORY

Do you have a past medical history of any of the following? (tick)

Hypertension (High blood pressure _____ Heart Disease _____

Hypercholesterolaemia (High cholesterol) _____ Lung Disease _____

Diabetes _____ Kidney Disease _____

Stroke _____ DVT _____

Family history of vascular disease_____ Please give details _____

SOCIAL HISTORY

SMOKING: Never smoked_____ Ex smoker _____ When did you cease _____

Still smoking _____ Number of cigarettes daily _____

ALCOHOL intake: Nil _____ Occasional _____ Weekly _____ Daily _____

CURRENT MEDICATIONS & ALLERGIES

Aspirin _____ Warfarin _____ DOSE _____

Other medications:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies_____

PREVIOUS OPERATIONS (Major)

Operations	Year	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIVACY STATEMENT

To comply with the Privacy Act 2001, all patients need to provide written consent for the following important aspects of their medical care.

- **I agree that Dr Mohabbat takes a full medical history that relates to my medical condition and management.**
- **I agree that relevant information may be obtained from other medical practitioners, such as GP's and specialists, other health care providers, pathologists, hospital and Day Surgery Units as necessary.**
- **I agree that Dr Mohabbat may discuss my medical history, diagnosis and management with my General Practitioner and other relevant Medical Specialists in relation to my medical management.**
- **I understand that I may apply to access my health records.**

PATIENT NAME.....

PATIENT'S SIGNATURE..... DATE .....