



Nose and Sinus Conditions
Complex Endoscopic Sinus Surgery
Rhinoplasty
Septum and Turbinates
Nasal Polyps
Snoring Surgery
Anterior Skull Base
Children's ENT:
Tonsils, Adenoids, Grommets



PATIENT DATA SHEET **CONFIDENTIAL** (See full privacy policy for details)

Title (please circle): Mr / Mrs / Ms / Miss / Dr / Other

Last name First name

DOB...../...../.....

Address

Home Phone Work Phone

Mobile..... Email

Preferred number (please circle): Mobile / Home Phone / Work Phone / Other.....

Preferred contact (please circle): Self / parent or guardian / relative or friend Name

Private Health Insurance (please circle): Yes / No Health Fund name

Private Health Insurance membership number

Medicare number Expiry date/...../..... Reference No

Veteran's Affairs number..... Expiry date/...../.....

Pension number..... Aged / Disability (please circle)

Contact for emergencies Phone.....

Relationship.....

Alternate contact for appointment confirmation..... Phone.....

Relationship.....

Would you like us to leave a message with these relatives regarding any appointment or medical related issues?

Yes / No (please circle)

Family doctor (Your GP) Phone.....

Address

Referring doctor (If different from above) Phone.....

Address

TEL: (02) 9680 8800

FAX: (02) 9680 8822

WEB: www.ents.com.au

EMAIL: contact@ents.com.au

HILLS/ NORWEST ROOMS

Norwest Private Hospital
Suite G6
11 Norbrik Drive
Bella Vista NSW 2153
Provider No 402690AB

All Correspondence To
Hills/ Norwest Rooms

ABN 51737769703

INSTITUTIONS

Westmead Public Hospital
Westmead Private Hospital
Norwest Private Hospital
Macquarie University Hospital
University of Sydney
NSW Health (Sydney West LHD)



PRIVACY POLICY: Our staff will not disclose this information to any third party. Your information is stored on a secure password protected information system. Onward referral to another specialist will require the duplication of this form, your record and test results. If results are not received by the practice, our staff may call the organisation that performed the tests to receive a fax copy. Your records and information may be kept by your doctor at another location. Your information may be used for billing purposes including bad debt management. If you do not give permission for the above please let our receptionist know. Access to your medical records may be allowed in accordance with the appropriate section of the National Privacy Act 1988.



PATIENT HISTORY SHEET **CONFIDENTIAL (See full privacy policy for details)**

MEDICAL HISTORY

Do you have any other medical problems? Please tick and provide details No other medical problems ☐

Tick ☒

- ☐ Heart (eg Heart attacks, chest pain, bypass, stent)
- ☐ Lungs/ Chest (eg Asthma)
- ☐ Brain (eg Stroke)
- ☐ Diabetes.....If Yes, are you treated with: ☐ Insulin ☐ Tablets ☐ Diet alone.....
- ☐ Bleeding Problems/ Clotting problems
- ☐ High Blood Pressure
- ☐ Kidney problems
- ☐ Thyroid Problems
- ☐ Liver Problems
- ☐ Cancer treatment.....
- ☐ Other

PREVIOUS OPERATIONS

Please list any previous operations/ surgical procedures.....No previous operations ☐

MEDICATIONS

Are you taking any blood thinning medications?Not taking any blood thinning medications ☐

- ☐ Aspirin (Cartia/ Cardiprin/ Dispirin/ Solprin/ Aspro/ Astrix/ Asasantin)
- ☐ Warfarin (Coumadin/ Marevan)
- ☐ Clopidigrel (Iscover/ Plavix)
- ☐ Arthritis medications (Non-steroidal anti-inflammatories: eg Voltaren, Ibuprofen, Indocid, Celebrex, etc)

Please list all other medications you are currently taking..... Not taking any other medications ☐

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THE UNIVERSITY OF
SYDNEY



**WESTMEAD
HOSPITAL**



Please list any drug allergies or medications you cannot take No known drug allergies ☐

.....
.....

SMOKING

Do you smoke now?

☐ Yes

☐ No

Have you smoked in the past?

☐ Yes

☐ No

Never smoked ☐

If Yes, how much do you smoke now, or in the past, on average?

☐ 2 or more packs per day

☐ 1 pack per day

☐ A few cigarettes per day

How many years in total have you smoked?.....Yrs

ALCOHOL

How many standard drinks do you take?..... Never take alcohol ☐

☐ drinks per day OR ☐ drinks per week

☐ Only on weekends/ social events

☐ Very rarely or not at all

FAMILY HISTORY

Please list any medical problems that run in the family No medical problems that run in the family ☐

.....
.....

OCCUPATIONAL HISTORY

Please list your current occupation and any previous significant occupations

.....

HEIGHT & WEIGHT

Height: cm / Feet and Inches Weight Kg / Stone / Pounds

FOR ADULT FEMALE PATIENTS

Are you pregnant?

☐ Yes

☐ No

☐ Not sure/ could be

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HOSPITAL

Thank you for completing this form. Your information will remain strictly confidential (See full Privacy Policy for details)