



*Rhinology (Nose and Sinus Conditions)*  
*Complex Endoscopic Sinus Surgery*  
*Blocked Nose*  
*Snoring & OSA Surgery*  
*Nasal Polyps*  
*Rhinoplasty*  
*Anterior Skull Base*  
  
*Children's ENT:*  
*Tonsils, Adenoids, Grommets*

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

Please tick : Mr Mrs Ms Miss Dr Other .....

Last name ..... First name .....

DOB...../...../..... Email.....

Address .....

Mobile..... Work Phone..... Home phone.....

Emergency contact: Name ..... Phone ..... Relationship .....

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

Pension number/ Veteran's affairs ..... Aged Disability Veteran (please tick )

Do you have private health insurance for **HOSPITAL?** Yes No (please tick )

If YES: Private Health Fund name..... Number .....

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

Address .....

Your current occupation and any previous significant occupations .....

**MEDICAL HISTORY** **\*\*CONFIDENTIAL\*\***

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

Heart (eg Heart attacks, chest pain, bypass, stents).....

Lungs/ Chest (eg Asthma) .....

Brain (eg Stroke) .....

Diabetes ..... If Yes, are you treated with: ..... Insulin ..... Tablets ..... Diet alone .....

Bleeding Problems/ Clotting problems.....  Blood pressure .....

Kidney/ Thyroid/ Liver problems.....

Cancer treatment .....

Other .....

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

**MEDICATIONS:** Are you taking any blood thinning medications? ..... No 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

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

Do you smoke now? Yes No.....cigs/day Smoked in the past? Yes No.....Years Never smoked

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

**FOR ADULT FEMALE PATIENTS:** Are you pregnant? Yes NoNot sure/ could be

**PLEASE SEND COMPLETED FORM TO: [contact@ents.com.au](mailto:contact@ents.com.au)**

**PRIVACY:** Our staff will not disclose this information to any third party not involved in your healthcare, unless required by law or you consent to it. Your information is stored on a secure password protected information system. Onward referral to another specialist may require the duplication of this form, your records and test results. If results are not received by the practice, our staff may call the organisation that performed the tests to receive a 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 Privacy Act 1988 (Cth). Please ask if you wish to see our full privacy policy.

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**INSTITUTIONS**

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



THE UNIVERSITY OF  
**SYDNEY**



**WESTMEAD**  
**ENT**