

**PATIENT INFORMATION SHEET FOR MR KON KOZAK**

[PatientNumber]

Patient: Mr/Mrs/Miss/Ms \_\_\_\_\_  
(Surname) \_\_\_\_\_ (Full Names) \_\_\_\_\_

Next of Kin: Name: \_\_\_\_\_

If child – who is responsible for the Account: \_\_\_\_\_

Address: Street & Suburb \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Name Referring Doctor and suburb seen at: \_\_\_\_\_

---

**PRIVATE PATIENTS** Medicare and health fund details

Medicare Card Number: \_\_\_\_\_ No.next to name: \_\_\_\_\_ Expiry: \_\_\_\_\_

Private Health Fund Name: \_\_\_\_\_ Date joined (if after 2014) \_\_\_\_\_

Membership No: \_\_\_\_\_

Are you a holder of an Age Or Department of Veteran Affairs Pension? (Please circle)

Reference no: \_\_\_\_\_

---

**Work Compensation/Motor Vehicle Related injury:** please complete the relevant section below:

**WORKERS COMPENSATION CLAIM**

Date of Injury: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Claim No: \_\_\_\_\_

**MOTOR VEHICLE INJURY**

Date of Accident: \_\_\_\_\_

Claim No: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

---

**CONSENT** all patients to please sign

I, the above patient, consent to the collection and use of the above information and all further information requested by any given to Dr Kozak during this and all subsequent consultations to help provide an accurate medical diagnosis and to facilitate appropriate treatment:

Signed: \_\_\_\_\_ date: \_\_\_\_\_

## MEDICAL HISTORY

## **PAST SURGICAL HISTORY**

**Please indicate history in relation to head, heart or lap band surgery; Y/N**

**if yes, please provide details:**

---

---

---

## **CURRENT MEDICATIONS**

Drug	Dose	Frequency
------	------	-----------

**SPECIFIC ILLNESS/INFORMATION (please circle)**

BLEEDING DISORDER	Y/N
DIABETES	Y/N
TAKING MEDICATION:	
INSULIN	Y/N
WARFARIN	Y/N
ASPIRIN	Y/N
BLOOD THINNING MEDICATION	Y/N
ANTI INFLAMMATORIES	Y/N
HEART DISEASE	Y/N
HIGH BLOOD PRESSURE	Y/N
PACEMAKER	Y/N
HEART VALVE DISEASE	Y/N
LUNG DISEASE	Y/N
LIVER DISEASE	Y/N
HISTORY:	
STROKE	Y/N
HEPATITIS (A) (B) (C)	Y/N
HIV	Y/N

ALLERGY TO:  
LATEX Y/N  
STICKY PLASTER Y/N

HAVE YOU BEEN IN HOSPITAL  
OUTSIDE W.A. IN PAST 12 MONTHS  
Y/N

## DRUG ALLERGIES

---

---

---