



PERSONAL DETAILS

Full Name..... M / F/...../...../
 Title Given Name(s) Surname Sex Date of Birth Age

Address..... Post Code.....

Telephone (H) (W) (M)

Email Occupation

Next of Kin..... Relationship..... Phone.....

Referring Doctor..... Address.....

Usual GP (if different)..... Address.....

How did you hear about Dr Miroshnik? (Tick all that apply)

- Word of Mouth
- Internet Search
- TV
- Vogue Magazine
- Other
- GP
- Bella Beauty Magazine
- Radio
- Harpers Bazaar Magazine
- Specialist/Other Health Professional
- Good Health Magazine
- Newspaper
- Cosmetic Surgery Magazine

Have you visited our website www.drmiroshnik.com.au? YES NO

HEALTH INSURANCE DETAILS

Medicare No..... Position No..... Expiry...../.....

Private Insurance YES NO Fund..... Membership No.....

Veteran Affairs No..... Worker's Compensation YES NO

HEALTH QUESTIONNAIRE

Height..... Weight..... Do you Smoke? YES NO How much?..... How long?.....

Alcohol Intake Never Occasional Daily Are you allergic to anything? YES NO If yes, please specify.....

Significant Medical Problems.....

Previous Operations

Regular Medications

Do you take Aspirin Steroids/Cortisone Warfarin Herbal Medications

Have you previously had any problems with local or general anaesthetic? YES NO

Do you have a history of any of the following (please circle)

- | | | | |
|-----------------|--------------------|---------------------|-----------------------|
| Asthma | Diabetes | High Blood Pressure | Blood Clots/DVT |
| Cold Sores | Heart Problems | Bad Scars | Immune Disorders |
| Wound Infection | Hepatitis B or C | HIV/AIDS | Epilepsy |
| Thyroid Disease | Bleeding Disorders | Arthritis | Psychiatric Treatment |