

Dr Michael Miroshnik
MBBS, FRACS (Plas.)
Plastic & Cosmetic Surgeon

Date.....

PERSONAL PARTICULARS

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 Dr.....Address.....

Phone.....Usual GP (if different).....

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

- Word of Mouth GP Specialist/ Other Health Professional
- Newspaper Yellow Pages Yellow Pages Online
- Internet Search..... Google Other Wentworth Courier Cosmetic Surgery Magazine
- Other Source

HEALTH FUND DETAILS

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

Private Insurance Yes No Fund.....Membership No.....

Veteran Affairs No.....Workers Compensation Yes No

HEALTH QUESTIONNAIRE

Height.....Weight.....Smoking Yes No...How much?.....How long?.....

Alcohol Intake Never Occasional Daily Allergy Yes No.....If yes, please state.....

Significant Medical Problems.....

Previous Operations.....

Regular Medications.....

Do you take? Aspirin Steroids/Cortisone Warfarin Herbal medications

Have you had any problems with local or general anaesthetics? Yes No

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

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

NOTE: If your personal details or medical condition ever changes in the future, please ensure you advise us