my genesis
TREATMENTS

patient information form

TITLE: .... FIRST NAMES: .... SURNAME: ....

ADDRESS: ....

SUBURB: .... STATE: .... POSTCODE: ....

DATE OF BIRTH: .... ETHNIC BACKGROUND: ....

MARITAL STATUS: .... OCCUPATION: ....

WORK PHONE: .... HOME PHONE: ....

MOBILE: .... EMAIL: ....

NEXT OF KIN: .... NEXT OF KIN PHONE: ....

PARENTS NAMES (IF PATIENT IS UNDER 18 YEARS): ....

HOW DID YOU HEAR ABOUT MY GENESIS? ....

MEDICARE NUMBER: .... CARD REF NO: .... EXP: ....

PRIVATE HEALTH FUND: .... MEMBERSHIP NO: ....

DVA NUMBER: .... CARD COLOUR: WHITE / GOLD

HCC/PENSION NUMBER: .... EXP: ....

FAMILY DOCTOR: .... SUBURB: .... PHONE: ....

REFERRING DOCTOR: .... SUBURB: .... PHONE: ....

KNOWN ALLERGIES: ....

DO YOU TAKE ANY *ANTI-INFLAMMATORY* OR *BLOOD THINNING* MEDICATION (E.G. ASPIRIN)? (PLEASE CIRCLE)

CURRENT MEDICATIONS / VITAMINS / MINERALS: ....

....

SURGICAL / MEDICAL HISTORY: ....

....

IF THIS CONSULTATION IS FOR INSURANCE OR WORKER'S COMPENSATION CLAIM PLEASE INFORM THE RECEPTION STAFF

PRIVACY STATEMENT: IT IS THE POLICY OF THE CAPS CLINIC THAT OUR PATIENT'S PERSONAL HEALTH INFORMATION WILL ONLY BE USED OR DISCLOSED IN THE PROVISION OF A PATIENT'S CARE. THE CLINIC HAS ESTABLISHED A PRIVACY POLICY IN COMPLIANCE WITH THE NATIONAL PRIVACY ACT OF 2001. COPIES OF THIS POLICY ARE AVAILABLE ON REQUEST.

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health history

TO ENSURE BOTH THE EFFECTIVENESS & SAFETY OF YOUR TREATMENT, PLEASE COMPLETE THIS HEALTH HISTORY AS ACCURATELY AS YOU CAN. THIS INFORMATION IS STRICTLY CONFIDENTIAL. IT ALLOWS US TO EVALUATE YOUR NEEDS SO WE CAN ACCURATELY DIAGNOSE, TREAT & PERFORM OUR SERVICES TO SUIT.

DO YOU SUFFER FROM A CONDITION STIMULATED BY LIGHT E.G. EPILEPSY, LUPUS?	YES / NO
ARE YOU A DIABETIC OR SMOKER?	YES / NO
HAVE YOU HAD RECENT FACIAL INJECTIONS? (IE COLLAGEN, BOTOX, SCULPTRA ETC)	YES / NO
DO YOU CURRENTLY HAVE SUNBURN / WINDBURN?	YES / NO
DO YOU COLOUR YOUR HAIR?	YES / NO
HISTORY OF MELANOMA / VITILIGO / HYPERPIGMENTATION / HYPOPIGMENTATION?	YES / NO
HAVE YOU HAD PREVIOUS LASER/PULSED LIGHT TREATMENTS?	YES / NO
HAVE YOU HAD SCLEROTHERAPY? (TREATMENT FOR VEINS)	YES / NO
DO YOU HAVE A PACEMAKER OR IMPLANT (S)?	YES / NO
HAVE YOU EVER USED ROACCUTANE OR ANY OTHER MEDICATION FOR ACNE?	YES / NO
DO YOU HAVE A HISTORY OF KELOID / HYPERTROPHIC / EXCESSIVE SCARRING?	YES / NO
HAVE YOU BEEN EXPOSED TO THE SUN OR ARTIFICIAL TANNING IN THE LAST 6 WEEKS?	YES / NO
HAVE YOU USED / CURRENTLY USING; RETIN A, AHA'S, GLYCOLICS, HYDROQUINONE ETC?	YES / NO
HAVE YOU EVER SUFFERED FROM COLD SORES, HERPES OR SHINGLES?	YES / NO
DO YOU HAVE TATTOOS OR PERMANENT MAKE-UP?	YES / NO
HAVE YOU HAD LASER RESURFACING, CHEMICAL PEEL, OR MICRODERMABRASION?	YES / NO
HAVE YOU WAXED, BLEACHED, PLUCKED OR HAD ELECTROLYSIS IN THE LAST 6 WEEKS?	YES / NO
ARE YOU ON A STRICT DIET (INCLUDING JUICES)?	YES / NO
FEMALE CLIENTS; ARE YOU PREGNANT OR LACTATING?	YES / NO
DO YOU SUFFER FROM AN ENDOCRINE DISORDER E.G. POS?	YES / NO

WATER CONSUMPTION PER DAY (PLEASE CIRCLE) NIL 1LT 2LT 3LT

ALCOHOL CONSUMPTION (PLEASE CIRCLE) NIL SOCIALLY DAILY

WHAT ABOUT YOUR SKIN BOTHERS YOU AND WHAT WOULD YOU LIKE TO HAVE CORRECTED?

....

....

I DECLARE THE INFORMATION CONTAINED IN THIS FORM IS TRUE, TO THE BEST OF MY KNOWLEDGE.

....	....	....
SIGNATURE (PATIENT / GUARDIAN)	PRINT NAME	DATE