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CONFIDENTIAL PATIENT QUESTIONNAIRE

The following information is requested to ensure that you are correctly identified in our records, to save you time, and to assist us in giving you the best possible care. All of the information which you provide will be treated as being strictly confidential: this practice conforms with the National Privacy Principles, and a copy of our Privacy Policy is available on request.

Please complete this questionnaire before arriving for your appointment or arrive 15 minutes early for your appointment and complete it at the clinic.

Title: _____ **Name:** _____ **Age:** _____

Date of Birth: _____ **Marital Status:** _____

Home Address: _____

_____ **Post Code:** _____

Postal Address (if different from above): _____

Phone (Home): _____ **Phone (Work):** _____ **Phone (Mobile):** _____

Occupation: _____ **Email Address:** _____

Emergency Contact Details (name and day/night time telephone numbers): _____

_____

Referring Doctor's Name and Address: _____

General Practitioner (if different to above): _____

Specialists you are currently seeing: _____

Medicare Number: _____ **Expiry Date:** _____ **# on card:** ____

Are you a War Veteran? _____ **Veterans' Affairs Entitlement No.:** _____ **Gold Card?** _____

The aim in this practice is for patients to be well-informed about their condition, and about any recommendations made for treatment. It is important therefore for you to say at the time if there is anything you do not understand, or about which you wish to know more. An exception to this occurs if you are referred for insurance or medico-legal assessment by a third party, when I am not at liberty to discuss your diagnosis or management.

Please note also that if you are given a follow-up appointment, it is important to attend. Otherwise, you may fail to receive important test results or advice. ***I do not and cannot take responsibility for your neurological care if you do not keep appointments which are made for you or do not follow the advice I give you.***

My fees for electroencephalography (EEG) and nerve-conduction studies/EMG studies and the related clinical consultation are routinely ***bulk-billed***. Any other tests will be quoted by the receptionist.

Prof. John L. Corbett
Consultant Neurologist
Credentialed Sleep Physician

PATIENT ACKNOWLEDGEMENT AND CONSENT

I have read the information set out on this form. I agree with this information and hereby consent to my medical details including any medical reports being released to my referring medical practitioner(s) and to any other medical practitioner(s) who treats me now or in the future including any other medical practitioner to whom Prof. Corbett refers me. My consent is based upon the understanding that such release is intended to be in the best interest of my health. If my referral has been for the purposes of Workcover or Medico-legal assessment, then I consent to the release of any such details or reports to the insurer or my solicitors at their request or to any other party with my solicitors consent.

I hereby give authorisation for any of my past medical records to be released to Professor John Corbett. To the best of my knowledge and belief all of the information I have provided is true and correct.

Signed By: _____ ***Date:*** _____

What are your **main health problems/symptoms** at present (start with the most troublesome one)?

1. _____
2. _____
3. _____
4. _____

Smoking and Alcohol:

Do you **smoke?** ☐ Yes (number per day: _____) What do you smoke? _____
☐ Have previously smoked (age started: _____ age ceased: _____)
☐ Never

How many **evenings per week** do you **drink alcohol?** ☐ _____ per week ☐ Never ☐ Special Occasions

How many **standard drinks** do you normally have per night? Minimum: ____ Maximum: _____ Average: _____

(A "standard drink" is one 285ml glass of standard beer, two 285ml glasses of light beer, small 100ml glass of wine)

Body Weight

What is your current **body weight?** _____kg

Amount of **weight gain** in past 12 months: _____kg and/or Amount of **weight loss** past 12 months: ____kg

Heart and Circulation:

Do you have **high blood pressure?** ☐ Yes ☐ No ☐ Medicated

Do you have **high cholesterol** and/or **high blood fats?** ☐ Yes ☐ No ☐ Medicated

Have you ever had any of the following **circulatory problems?** (please circle any that apply)

Heart attack (myocardial infarction), heart failure, ischemic heart disease, atherosclerosis, cardiac bypass surgery, cardiac angioplasty (stent), peripheral oedema (right heart failure), valve replacement, stroke, TIA, palpitations, cardiac arrhythmia (e.g., atrial fibrillation, ventricular ectopy)

What is the name of your **cardiologist?** _____

Have you had an **echocardiogram** performed recently? ☐ Yes ☐ No (if yes, where? _____)

Lung Disease:

Have you ever had any of the following **lung problems** (please circle)?

Obstructive lung disease (e.g., COPD, asthma), chest wall disease (e.g., kyphoscoliosis), hypercapnic respiratory failure (increased CO2), emphysema

Details: _____

What is the name of your **respiratory physician?** _____

Restless Legs / Peripheral Nerves

Do you get an **irresistible urge to move your legs** or **uncomfortable sensations** in your legs when you sit down and relax at the end of the day or when you are in bed at night? 0 1 2 3

Is the urge to move your legs **partially or totally relieved by moving** them? ☐ Yes ☐ No

Do you get numbness or "*pins and needles*" sensations in your hands or feet? ☐ Yes ☐ No

Any additional comments: _____

_____

_____

General Medical History (please *circle* the condition and indicate approximately when it was diagnosed)

Kidney disease, kidney stones, bladder problems _____
Gastric or duodenal ulcer, bowel disorder, liver disorder _____
Hepatitis A, B, C; contact with HIV / AIDS _____
Anaemia, excessive bleeding, other blood disorder _____
Diabetes, thyroid disorder, other endocrine disorder _____
Anxiety, depression, other psychiatric disorder _____
Arthritis, joint or bone disorder _____
Neuromuscular disease (e.g., muscular dystrophy) _____
Epilepsy, seizures, blackouts, other neurological disorder _____

_____

Do you take any **non-prescribed** or **recreational drugs** (please specify)_____

_____

Do you have any **allergies?** _____

Have you had any serious **accidents** or **past hospital admissions?** (indicate approximate dates and details)

_____

_____

Please note any **other information** you feel is relevant: _____

_____

_____

Please list all **current medications:**

Medication Name	*Reason for Medication*	*Dosage*

If there is not enough room on this page to list your medications, please attach a separate sheet.

Family History:

Please indicate any known family diseases (if deceased, please indicate the cause of death and age at death):

- Mother: _____ • Father: _____
- Maternal grandmother: _____ • Maternal Grandfather: _____
- Paternal grandmother: _____ • Paternal Grandfather: _____

Please note any **other information** you feel is relevant: _____

_____

_____

_____

_____