REGISTRATION INFORMATION FOR PATIENTS SEEING PROF RICHARD PRINCE

To be completed when you first see Prof Prince or if you have not been reviewed for 12 months
Copies available on the web site www.princeendocrinology.com.au

SURNAME: _____

GIVEN NAMES: _____

DATE OF BIRTH: _____

ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

MOBILE PHONE: _____

EMAIL: _____@_____

NEXT OF KIN / LOCAL CONTACT NAME: _____

NEXT OF KIN RELATION TO YOU: _____

NEXT OF KIN / LOCAL CONTACT ADDRESS: _____

NEXT OF KIN / LOCAL CONTACT PHONE NO: _____

GP NAME: _____

GP PRACTICE NAME: _____

GP ADDRESS: _____

_____

GP PHONE NUMBER: _____

GP EMAIL: _____@_____

MEDICARE CARD NO: _____ **Ref No:** ____ **Expiry Date:** _____

HOSPITAL PRIVATE HEALTH INSURANCE COMPANY NAME (if applicable): _____

PRIVATE HEALTH INSURANCE MEMBER NO. (if applicable): _____

DVA NUMBER (if applicable): _____

PENSION CONCESSION NUMBER (if applicable):_____

Privacy Statement I consent to the collection and use of the above information, and all further information requested by and given to staff of Prof Prince during this and all subsequent consultations, to help provide accurate medical diagnosis and to facilitate appropriate treatment, including correspondence to my referring doctor / general practitioner

Signed: _____ **Date:** _____

Overleaf please explain why you want to see Prof Prince and what health problems you would like addressed.

Prof Richard L Prince **PATIENT HEALTH QUESTIONNAIRE**

Name: _____ Date: _____

Please describe briefly the major reason(s) why you are seeing Prof Prince. There are specific questions for those with osteoporosis, diabetes and thyroid disease at the end of this questionnaire.

_____

_____

_____

_____

List any current illness or medical problems with dates when started *and* ***medication*** if any. Also bring a ***complete list of your current medications***

_____

_____

_____

_____

_____

Have you taken steroids (cortisone)? Yes / No How much? _____ When? _____

Lifestyle questions.

Do/did you smoke? How much? _____ When? _____

Do you avoid any specific foods?_____

How much alcohol do you drink per day ? _____

How much milk do you drink per day? _____

How much cheese do you ea per day t? _____

How much exercise do you take per week? _____

Family / genetic/ social history

What diseases have your relatives had? (e.g. diabetes, breast cancer, osteoporosis)?

Father _____Mother _____

Brother/Sister _____Other Relatives _____

Are there other relevant Family/Social problems? _____

Other medical symptoms

If you have any of the following symptoms describe with timing

Headache? Yes / No _____

Blackout? Yes / No _____

Dizziness or unsteadiness? Yes / No _____

Weakness or numbness of limbs? Yes / No _____

Visual Problems? Yes / No _____Hearing Problems? Yes / No _____

Shortness of breath? Yes / No With exercise? _____ In bed at night? _____

Chest Pain? Yes / No _____Ankle Swelling? Yes / No _____

Palpitations? Yes / No _____

Cough Sputum Yes / No

White? Yes / No _____ Yellow? Yes / No _____Blood stained? Yes / No _____

Wheeze? Yes / No _____

Tooth or jaw disease? Yes / No _____

Nausea? Yes / No _____Vomiting? Yes / No _____

Difficulty Swallowing? Yes / No _____Loss of Appetite? Yes / No _____

Change in Weight? Yes / No_____ Indigestion? Yes / No _____

Abdominal Pains? Yes / No _____Constipation? Yes / No _____

Diarrhoea? Yes / No _____

Frequency of Urination? Yes / No _____

Blood in Urine? Yes / No _____

Getting up at night to pass urine? Yes / No _____

Incontinence of urine? Yes / No _____

Poor urine flow? Yes / No _____

Joint symptoms? Yes / No list the joints affected and when?_____

_____

Do you have any bone disease? Yes / No If so what? _____

Have you had any fractures ? Yes / No

What bone? _____ When? _____ How? _____

What bone? _____ When? _____ How? _____

What bone? _____ When? _____ How? _____

What bone? _____ When? _____ How? _____

Thyroid

Do you have or have you had any sort of thyroid disease? Yes / No

What was the diagnosis? _____ When? _____

_____

Diabetes

Do you have diabetes? Yes / No When was it diagnosed? _____

Do you have diabetes damage to:

Your eyes? Yes / No _____ Your kidneys? Yes / No_____ Your feet? _____

WOMEN

Age at first period (approximately) _____Age at menopause (approximately) _____

Abnormal frequency or length of periods? Yes / No _____

Abnormal hair growth Yes / No?_____ Libido concerns? _____

Breast lumps? Yes / No _____Breast tenderness? Yes / No _____

Hot flushes? Yes / No _____

MEN

Hair growth problems? Yes / No _____ Muscle strength concerns? Yes / No _____

Libido concerns? Yes / No _____Erection concerns? _____

Any other comments?

Thank you