

NEW PATIENT DETAILS

Surname _____ Title: _____

First Name: _____ Middle Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____

Home Phone: _____ Work: _____ Mobile: _____

Email: _____

Occupation: _____ Parents' Name (if under 18 years old): _____

Next of Kin: _____ Next of Kin Contact Number _____

REFERRING DOCTOR:

Name: _____

Date of Referral: _____

Address: _____ Phone: _____

GENERAL PRACTITIONER (if not as above)

Name: _____

Address: _____ Phone: _____

HEALTH INSURANCE DETAILS:

Medicare No: _____ Expiry: _____

Position: _____ Private Health Fund Name: _____ Fund No: _____

Position: _____ Veterans Affairs: _____

HOW DID YOU HEAR ABOUT DR YUNAEV OR BREAST & BODY CLINIC? (Tick one or more)

- | | |
|--|--|
| <input type="checkbox"/> GP | <input type="checkbox"/> Instagram |
| <input type="checkbox"/> Specilaist | <input type="checkbox"/> TV |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Magazine |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Word of Mouth |

Referred by a friend (Name?) _____

Have you visited our website www.bbclinic.com.au? Y N

Have you liked our Facebook page ? Y N Instagram? Y N

PLEASE ADVISE US IF YOU ARE MAKING A CLAIM FOR COMPENSATION FEES

This is a private practice and we do not bulk bil.
The fees charged by this practice are generally higher than those recommended by the Australian Medical Association and are payable at the time of consultation.

Initial Consultation \$290.00
Subsequent Consultation \$145.00

The following payment methods are available: Cash, Cheque, EFTPOS (Visa, MasterCard, AMEX and Debit only)

Please note, if paying with Credit Card, surcharge of 1.5% for AMEX, VISA and Master Card will apply.

If you are paying in cash, please note that we do not keep cash on the premises, the exact payment is appreciated.

BREAST COMPLAINT PATIENT QUESTIONNAIRE

Describe your Current Problem/Issue:

Symptoms	Right	Left
Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>
Nipple Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Nipple retraction/ inversion	<input type="checkbox"/>	<input type="checkbox"/>
Skin Changes/ rash/ scaling	<input type="checkbox"/>	<input type="checkbox"/>
Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/ Redness	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify):

Recent Investigations (date, where, results):

Mammogram: _____

Ultrasound: _____

MRI: _____

Breast Biopsy: _____

Other: _____

Family History of Breast / Ovarian problems (specify maternal/paternal, age at diagnosis and if more than one cancer in same person):

Risk Factors Assessment

Age at Menarche (first period)? _____

Age at Menopause? _____

Number of pregnancies and number of live births? _____

Age at first child's birth? _____

Did you breastfeed and for how long in total? _____

Do you or did you use HRT (hormone replacement therapy) and for how long? _____

When did you stop HRT? _____

Do you or did you use OCP (oral contraceptive pill) and for how long? _____

Breast density on mammogram if known? _____

Alcohol consumption (standard drinks per day)? _____

Are you overweight/obese? _____

Smoking status (if stopped when)? _____

Family History of Breast Cancer? _____

Ashkenazi Jewish Heritage? _____

Previous Medical History (tick where appropriate):

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Raised Cholesterol | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Heart Attack/Stent insertion | <input type="checkbox"/> Bipolar Disorder/Psychosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer history |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Sleep Apnoea | <input type="checkbox"/> Deep vein thromboses |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Problems with anaesthetic eg. vomiting |
| <input type="checkbox"/> Prosthetic devices/Implants | <input type="checkbox"/> Problems with keloid or thick/ugly scars |

If you ticked yes above please provide further information:

Other conditions not listed above:

Previous Surgical History (list procedures and dates):

Do you use blood-thinning medications? What are they?

List your other medications:

Do you have any Allergies?

Social Environment:

What is your current or previous occupation?

Who do you live with? / Who is at home with you?

Do you have children? What are their ages?

Do you require assistance with daily activities?

Do you require a chaperone (an accompanying person in the room) to be present during your clinical examination? Yes _____ No _____

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CONSENT

SOCIAL MEDIA / PHOTOGRAPHY

I consent to the use of my de-identified pre and post surgery images to be used for medical education, consultation and/or promotion on the following digital platforms (please cross out any points that you DO NOT consent to):

- Medical Journal publications, Medical presentations
- Email
- Facebook
- Instagram
- Snapchat

PRIVACY NOTE

I agree to allow for the doctors and staff at this practice to access all relevant information regarding my medical conditions. I agree that the doctors and staff may be required to forward/obtain information about my medical history/condition from the referring doctor and/or other health professionals. I understand my clinical records may be accessed or reviewed by staff at this practice.

I hereby certify that the medical information I have provided above is true and accurate to the best of my ability.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery Fees and I will also be responsible for any legal costs incurred.

I declare that, to the best of my knowledge, the information I have provided in the form is accurate:

Signature: _____ Date: _____

If under 18 years old, please sign by parent:

Name: _____ Best Contact number: _____

PATIENT NAME: _____ Date of Birth: _____

Our Clinic offers Anti-Aging Cosmetic Injection service, is this of interest to you? Yes _____ No _____

If Yes, would you like to book in for a Free Consultation to discuss this further? Yes _____ No _____