

## ONDA New Patient Form

### 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 \_\_\_\_\_

### 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"/> Facebook      | <input type="checkbox"/> Internet Search |
| <input type="checkbox"/> Specialists | <input type="checkbox"/> TV        | <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Magazine        |

Referred by a friend (Name?) \_\_\_\_\_

Have you visited our website [www.bbclinic.com.au](http://www.bbclinic.com.au)? Y  N

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

Describe your Current Problem/Issue:

\_\_\_\_\_

Other Symptoms present (please specify):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Do you have ANY current or chronic skin conditions?  Yes  No

Also disclose any history of eczema, psoriasis, allergic dermatitis, any diseases affecting collagen, scleroderma, skin cancer, or any other skin condition.

Please list:

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Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?  Yes  No

Please list:

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Do you have ANY heart implants/pacemakers or any other implantable devices?  Yes  No

(For women) are you or could you be pregnant?  Yes  No

Do you have a history of skin disorders stimulated by heat, such as recurrent Herpes Simplex in the treated area?  Yes  No

Do you have any open sores or lesions?  Yes  No

Do you have any rashes, inflammation, infection or hematoma in the area to be treated?

Yes  No

Do you have any history of radiation therapy in the area to be treated?  Yes  No

Do you have or have you ever had a hernia?  Yes  No Specify location: \_\_\_\_\_

Do you have any tattoo or permanent make-up in the treated area?  Yes  No

Do you have a history of fainting or passing out?  Yes  No

Have you had any unprotected sun exposure or used tanning beds or lamps in the last week?

Yes  No

Do you consider yourself to have an anxious or nervous personality?  Yes  No

Do you consider yourself claustrophobic or have issues with confinement?  Yes  No



Previous Surgical Medical History (list procedures and dates):

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

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List your other medications:

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Do you have any Allergies?

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**DO YOU SMOKE OR VAPE?**

- smoker
- ex-smoker
- never smoked

**SOCIAL ENVIRONMENT:**

What is your current or previous occupation? \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Do you have children? What are their ages? \_\_\_\_\_



**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:** \_\_\_\_\_