DR ROBERT S SCHMIDLI
MB CHB, MRCP, FRACP, PHD

CONSULTANT PHYSICIAN,
DIABETES AND ENDOCRINOLOGY

Suite 26,
John James Medical Centre,
175 Strickland Crescent,
DEAKIN ACT 2600

TEL: (02) 6282 9962
FAX: (02) 6282 4117
Email: endo@schmidli.com.au
WWW: www.schmidli.com.au

Provider Number: 0960947T

1. Your personal details

First Name: _____ Middle Name:_____ Surname: _____

Title: Mr / Mrs / Ms / Dr / Prof Date of birth: _____/_____ / _____

Marital status: Single/Married/Separated/Divorced/Widowed/De Facto

Street address: _____

Suburb: _____ Postcode:_____

Email: _____

Phone: Home:_____ Work:_____ Mobile: _____

Next of kin: _____Phone: _____

Private Health Fund: _____Membership No _____

Medicare card No: _____ Your Position on card __ Expiry Date:____/___

Have you given Medicare your bank account details to enable electronic claiming? Yes / No

D.V.A. or Pension Card No _____ Current occupation _____

Local doctor (GP): _____

Referring doctor (if different) _____

2. Existing medical conditions

Have you *ever* had any of the following conditions? Please tick (☑) each box that applies:

☐ Asthma
☐ Tuberculosis
☐ High or low blood pressure
☐ High blood cholesterol
☐ Heart disease or heart attack
☐ Rheumatic fever
☐ Heart rhythm disturbances
☐ Heart failure
☐ Stomach ulcers
☐ Hepatitis, jaundice or liver disease
☐ Heartburn or indigestion
☐ Diabetes
☐ Bowel disorders
☐ Kidney disease or stones
☐ Stroke
☐ Epilepsy (fits or seizures)
☐ Migraines
☐ Arthritis
☐ Gout
☐ Thyroid disease
☐ Blood or bleeding disorders
☐ Skin disorders (such as eczema)

3. Past hospital admissions or serious illnesses

Please give details of any previous stays in hospital or serious illness:

Year	Reason (describe the problem, diagnosis or operation)

Please continue on next page →

4. How you have been feeling lately

Do you experience any of these symptoms at the moment? Please tick (☑) boxes that apply:

- ☐ Difficult breathing
- ☐ Swollen ankles
- ☐ Chest pains
- ☐ Constipation or diarrhoea
- ☐ Stomach pains
- ☐ Excessive tiredness or weakness
- ☐ Poor appetite
- ☐ Weight loss (amount loss: _____kg)
- ☐ Nausea or vomiting
- ☐ Frequent or unusual headaches
- ☐ Dizziness, spinning or vertigo
- ☐ Faints or blackouts
- ☐ Bladder problems
- ☐ Double or blurred vision
- ☐ Unusual bleeding
- ☐ Stomach pain or cramps
- ☐ Muscle aches
- ☐ Joint pains
- ☐ Pain in any other part of your body

5. Your medications

Please list all medications you are taking,. Also include over-the-counter drugs:

Name of medication	**Reason (e.g. blood pressure)**	**Dose**	**Frequency**

Please list any drug **allergies** or **reactions** you have had at any time in the past.

Name of drug	Type of reaction	Year it happened

Do you **smoke**? Yes / No. If yes, how much do you smoke a day? _____

How many **standard alcoholic drinks** would you usually have in a day? _____ Drinks

6. Family history

Please list any diabetes, thyroid or cardiac conditions or any other conditions that run in your family. Please tick (☑)and provide details:

	Family member	**Condition**
☐	Children	_____
☐	Brother(s) or sister(s)	_____
☐	Parents	_____
☐	Grandparents	_____
☐	Uncles or aunts	_____

I, _____ hereby authorise that any information relating to my medical history be made accessible to Dr Robert Schmidli if requested. I also agree to my consultation to be held by telehealth.

Signed: _____ Date:____/____/____