

SKIN @ MEDICINE ON SECOND

PATIENT NAME:

PATIENT D.O.B

Thank you for visiting Skin @ Medicine On Second To assist us in providing you with the best possible service and care, we require the following information. These details remain private and confidential and will only be used in relation to this consultation and any on going treatment you may require.

MEDICAL INFORMATION

Please list all medical conditions that you are receiving treatment for:

Are you currently taking **any medications to thin the blood** YES NO
(e.g. Aspirin, Warfarin, Clopidogrel?) If yes, please specify medication here:

Do you have a cardiac **pacemaker** ? YES NO

Are you **allergic** to medications, sticking plasters or antiseptic solutions ? YES NO
Details if yes:

Have **you** previously been treated for **Melanoma or skin cancer** ? YES NO

Has anyone in your immediate **family** had a **Melanoma**? YES NO

Has anyone in your immediate family had **other** (Non-Melanoma) **skin cancer**? YES NO

Are you **pregnant or breast feeding**? YES NO

I understand that Melanomas can arise in any part of the body, so I hereby consent to either:

(Please tick ONE of these two)

A full examination of my body

A limited examination as indicted during the consultation

Please tick ONE of these two:

I wish to bring a companion to be present at my examination

OR

I do not wish to bring a companion to be present

How did you find out about our skin cancer services? (please circle if filling in by hand or click on button if filling in electronically)

- | | | | |
|----------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> White Pages | <input type="checkbox"/> Holiday Accom | <input type="checkbox"/> Relatives |
| <input type="checkbox"/> Signage outside practice | <input type="checkbox"/> Drive / Walked past | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Leaflets / flyer |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> School newsletter | <input type="checkbox"/> Bowls club | <input type="checkbox"/> The Weekender |
| <input type="checkbox"/> Radio 91.9 What's up Doc? | <input type="checkbox"/> Kids on the Coast | <input type="checkbox"/> Beach House Fitness | <input type="checkbox"/> SALT magazine |
| <input type="checkbox"/> Beyond Blue | <input type="checkbox"/> Search engine – google | <input type="checkbox"/> Search engine – other | <input type="checkbox"/> Link from a website |
| <input type="checkbox"/> Sunshine Coast Tourism magazine | <input type="checkbox"/> Already a patient | <input type="checkbox"/> Other (please specify) | |

CONSENT

By signing below I acknowledge that I have understood the above information and consent to have a Siascope examination.

Patients Name:

Signature: