

CALIBRE NEW PATIENT QUESTIONNAIRE

PATIENT DETAILS

Title _____ Surname _____ Given Names _____

Home Address _____

Suburb _____ Postcode _____

Postal Address (if different from above) _____

Suburb _____ Postcode _____

Phone (Home) _____ (Work) _____ Mobile _____

Email Address _____ Date of Birth _____

MEDICAL DETAILS

Are you on any medications? (Please list) _____

Have you had problems with:

MRSA Epilepsy Diabetes Auto Immune Diseases

Anaesthetic Blood Clotting Asthma Have you ever smoked

Do you smoke? (If so, how many per day) _____

Do you have any allergies? (Please list) _____

Have you ever had surgery? (Please list) _____

Please list all vitamin / mineral supplements you are currently taking _____

Do you suffer from Haemophilia or Von Willbrands Disease? Yes No

MEDICARE DETAILS

Medicare No _____ Reference No _____ Expiry Date _____

CALIBRE CLINIC

calibreclinic.com.au
enquiries@calibreclinic.com.au
@calibreclinic

SUBIACO

1300 105 505
Suite 1A, Arcadia Chambers
1 Roydhouse Street, SUBIACO WA 6008

SYDNEY

1300 105 505
Ground Floor, 121 Alexander Street
CROWS NEST, SYDNEY NSW 2065

MELBOURNE

1300 105 505
657 Burwood Road
HAWTHORNE EAST VIC 3132

BRISBANE

1300 105 505
Level 2, 70D Mary Street
BRISBANE QLD 4000

EMERGENCY CONTACT

Next Of Kin _____ Relationship _____

Phone (Home) _____ Mobile _____

REFERRAL DETAILS

Referring Doctor _____ Suburb _____ Referral Date _____

Usual Doctor _____ Practice Name _____

How did you hear about us?

- | | |
|--|--|
| <input type="checkbox"/> Website – CALIBRE | <input type="checkbox"/> Website – Phalloboards |
| <input type="checkbox"/> Website – Academy Face & Body | <input type="checkbox"/> The Penis Podcast / Youtube |
| <input type="checkbox"/> Social Media – FB / Instagram | <input type="checkbox"/> Referral – Doctor, Friend, Family |

PRIVACY POLICY & CONSENT

- I have read, understand and accept the [CALIBRE Clinic NPQ Privacy Policy](#).
- I consent and authorise the release of my medical records, including current and previous medical records from other practices and practitioners, hospitals and / or clinics which are part of my medical records.
- (Telehealth / Video / Phone Consultations ONLY) I have read and accept the [CALIBRE Clinic Video Phone Policy](#) and understand that I might not receive all of the potential benefits of a telehealth consultation. I understand the potential risks involved and agree to proceed with a telehealth consultation.
- I have read, understand and accept the [CALIBRE Clinic Financial Consent](#).
- I agree the information I have supplied is true and correct to the best of my knowledge.

Please email completed form to enquiries@calibreclinic.com.au

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