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 _____

How much do you weigh currently? _____

Do you suffer from Haemophillia or Von Willbrands Disease? ☐ Yes ☐ No

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

MEDICARE DETAILS

Medicare No _____ Reference No _____ Expiry Date _____

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?

- ☐ Website – CALIBRE
- ☐ Website – Academy Face & Body
- ☐ Social Media – FB / Instagram
- ☐ Website – Phalloboards
- ☐ The Penis Podcast / Youtube
- ☐ 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.

Signature: _____ Date: _____

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