Patient ID: _______________

Patient Information Form – My Genesis

Title: ________ First Names: ________________________ Surname: _________________________

Address: ____

Suburb: ______________________ State: ___________________ Postcode: ___________________

Date of Birth: _____/______/___________ Ethnic Background: _____________________________

Marital Status: _______________________ Occupation: ____________________________________

Home Phone: ________________________ Work Phone: ____________________________________

Mobile: _____________________________ Email: ____

Next of Kin: __________________________ Next of Kin Phone: _____________________________

Next of Kin Relationship: _______________ Guardian (if patient is under 18 years): _____________

How did you hear about The CAPS Clinic? ____

Would you like to receive updated information from The CAPS Clinic? Yes ☐ No ☐

Medicare Number: ____________________________ Card Ref No: _____ Exp: _____/___________

Private Health Fund: __________________________ Membership No: ________________________

DVA Number: ________________________________ Card Colour: White / Gold

HCC/Pension Number: _________________________ Exp: ________/_________/_____________

Family Doctor (full name): __________________________ Clinic/Suburb: ______________________

Referring Doctor (full name): ________________________ Clinic/Suburb: ______________________

Known Allergies: ____

Do you take any Anti-Inflammatory/Blood Thinning medication (Eg. Aspirin, Ibuprofen) (Please circle)

Current Medications / Vitamins / Minerals: ____

____

Surgical / Medical History: ____

____

COVID-19 Immunisation First Dose ☐ Second Dose ☐ Unvaccinated ☐

If this consultation is for Insurance or Worker's Compensation Claim please inform the Reception Staff

Privacy Statement:

It is the policy of The CAPS Clinic our patient's personal health information will only be used or disclosed in the provision of a patients care. The clinic has established a privacy policy in compliance with the National Privacy Act of 2001. Copies of this policy are available on request.

Do you suffer from a condition stimulated by light? (Eg. Epilepsy, Lupus)	YES / NO
Are you a Diabetic or have Impaired Skin Sensation/Problems with healing?	YES / NO
Do you Smoke?	YES / NO
If so how many per day? _______________ Planned quit date? _______________	
Do you have a Pacemaker or Implant(s)?	YES / NO
Do you have a history or Keloid / Hypertrophic / Excessive scarring?	YES / NO
Is there a history of Melanoma / Vitiligo / Hyperpigmentation / Hypopigmentation?	YES / NO
Have you ever suffered from Cold Sores, Herpes or Shingles?	YES / NO
Have you had recent Facial Injections? (Eg. Filler, Botox)	YES / NO
Have you previously had Laser / Pulsed Light treatments?	YES / NO
Have you had Sclerotherapy? (Injections for leg veins)	YES / NO
Have you had Resurfacing (Eg. Fraxel/CO2), Chemical Peel, or Microdermabrasion?	YES / NO
Do you colour your hair?	YES / NO
Do you have Tattoos or Permanent Make-up in the area(s) of concern?	YES / NO
Have you Waxed, Bleached, Plucked or had Electrolysis in the last 6 weeks?	YES / NO
Do you currently have Sunburn / Windburn?	YES / NO
Have you ever used Roaccutane or any other medication for acne?	YES / NO
Have you used / or currently using; Vitamin A/Retinol, AHA's, Glycolics, Hydroquinone etc.?	YES / NO
Have you been exposed to the Sun or Artificial Tanning in the last 6 weeks?	YES / NO
Are you on a strict diet? (Including Juices)	YES / NO
Water consumption per day (please circle) Nil 1lt 2lt 3lt+	
Alcohol consumption (please circle) Nil Socially Daily	

Female Clients

Are you pregnant or lactating? YES / NO

Do you suffer from an endocrine disorder eg. PCOS? YES / NO

Skin Consult Clients Only

What about your skin bothers you and what would you like to have corrected?

____

What is your current skincare regime?

____

____

I declare the information contained in this form is true, to the best of my knowledge

______________________ ______________________ ______________________

Signature-Patient or Guardian Print Name Date

Please also hand Medicare card to reception staff