



# Brisbane Breast Implant

Strathpine Specialist Centre  
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**Dr Philip Scarlett**

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DATE:     /     /

**CONSULTATION FORM**

TITLE: \_\_\_\_\_

**SURNAME:** \_\_\_\_\_ **DOB:**     /     /

**FIRST NAME:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: M: \_\_\_\_\_ H/W: \_\_\_\_\_

Email: \_\_\_\_\_

**Medicare no:** \_\_\_\_\_ **Expiry Date:**     /     /

Reference no. on card: \_\_\_\_\_

**Private Health Insurance:** Yes / No

Health Fund Name: \_\_\_\_\_ Membership no: \_\_\_\_\_

**MEDICAL HISTORY**

What is your current height: \_\_\_\_\_ weight: \_\_\_\_\_

Have you suffered from or do you receive treatment for: (tick all that apply)

Do you have: Hepatitis Y / N     HIV Y / N     Diabetes Y / N

Previous or current medical/psychiatric conditions (including anxiety and depression)

\_\_\_\_\_

\_\_\_\_\_

Previous operations (please include any cosmetic procedures) and year performed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** \_\_\_\_\_

Smoker: Y / N     \_\_\_\_\_ per day     \_\_\_\_\_ when quit

Alcohol: Y / N     \_\_\_\_\_ type and amount per day

Do you bleed more easily than average? Y / N

Are you on blood thinning medications (eg Warfarin, Plavix, Aspirin)? Y / N

Do you get excessive or keloid type scars? Y / N

**Medications**(including herbal)\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

General enquiry:

How did you hear of Dr Philip Scarlett?

Internet: our website/ Google search

Doctors referral: (name)\_\_\_\_\_

Advertisement (where)\_\_\_\_\_

Friend/Relative\_\_\_\_\_

Beautician referred? \_\_\_\_\_

Other? \_\_\_\_\_

**End of patient completed section**

OFFICE USE ONLY

PROCEDURE	FEE	GST	TIME	MBS ITEM NO.	PRIVATE COVER	THEATRE/ GA PAY DIRECT	IMPLANTS

CALL TO OFFER TIME

CONSIDERING