NEW PATIENT DETAILS

This form preserves your privacy, as personal details will not be asked in presence of other patients. Once details are entered into your secure file this document is destroyed.

Surgeon to whom you are seeing:

Title: Surname:

Given name: Preferred name:

Date of Birth:

Home Phone: Work Phone: Mobile:

Would you like to receive an Appointment Confirmation Reminder via Txt Message? ☐Yes ☐ No

Postal Address:

Suburb: Postcode:

Email address:

Name of Referring Doctor: Usual GP:

Medicare Care Number: (10 digits) _ _ _ _ _ _ _ _ _ _ _ Ref. next to your name: _ Expiry:

Do you have Private Health Insurance: Yes No

Name of Fund: Membership No:

Veterans Affair Card Number: Gold / White (Please circle)

Condition Covered:

*Next of Kin (s): Relationship: Contact no:

**If completing for a child under 18 - we will ONLY speak to NOK listed above.*

Insurance/Compensation Claim: Claim No:

Case Manager:

PLEASE READ:

As a health care provider in the private sector the Reef Orthopaedic Clinic is bound by the Australian Privacy Principles (March 2014) provided in the Privacy Act 1988. These govern how we collect, handle, use, distribute and store personal information collected from our patients at the clinic. Ordinarily we don't release the contents of your file without consent. However, there may be occasions when the law requires us to disclose certain information without your consent. When dealing with other health care professionals, in order to obtain accurate diagnosis or treatment options we will ask your full consent to disclose personal medical details. Please indicate below and sign your consent for details to be disclosed when necessary.

☐I Do **☐Do Not**

(Please Tick Box) give permission for details relating directly to my medical condition be discussed with other health care professionals so that the highest standard of care may be achieved.

Patient Name: **Signature:**

NOW COMPLETE SECOND PAGE ……..THANK YOU

HEALTH QUESTIONNAIRE

Please read the following and tick if applicable to you. This information is for our staff to help us look after you and optimise your treatment.

Are you a diabetic? ☐Yes ☐ No

If **Yes**, what type? ☐ Diet ☐ Tablets ☐Insulin

Are you a smoker? ☐Yes ☐No If **Yes** how many per day…….

If **Yes**, are you aware that smoking has serious adverse effects on skin and bone healing? ☐Yes ☐No

Are you currently taking any medications?
(Please include vitamins or homeopathic supplements) ☐Yes ☐No

If **yes,** please list……..

Are you on any of the following drugs?

Wafarin ☐Yes ☐No Aspirin ☐Yes ☐No Clopidogrel ☐Yes ☐No
Insulin ☐Yes ☐No Methotrexate ☐Yes ☐No Prednisolone ☐Yes ☐No
Pradaxa ☐Yes ☐No

Do you have any allergies? ☐Yes ☐No

If so please list:……

Have you had any problems with an anaesthetic? ☐Yes ☐No

Have you had any of the following in the last 12 months:
Heart attack or Stroke? ☐Yes ☐No

Had a Stent or a Pacemaker inserted? ☐Yes ☐No

Have you ever had a blood clot (DVT/ PE)? ☐Yes ☐No

Do you suffer from Arthritis? ☐Yes ☐No

Do you have Vascular Disease? ☐Yes ☐No

Do you live alone? ☐Yes ☐No

If **No**, with ☐Husband ☐Wife ☐Partner ☐Parents ☐Friend

If **Yes**, do you have someone close to you that can help you recuperate? ☐Yes ☐No

Do you have stairs at home? ☐Yes ☐No

At work are you mainly? ☐Seated ☐ Standing ☐Walking ☐50/50 ☐ Retired

Can you modify your work after surgery? ☐Yes ☐No

Do you realise that excess weight significantly increases your risk of complications? ☐Yes ☐No