DANIEL SYDENHAM
ORTHOPAEDIC SURGEON

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NEW PATIENT FORM

PATIENT DETAILS:

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Master ☐ Dr. ☐ Prof. ☐ Other ☐

Date of birth: _____ / _____ / _____

Surname: _____ Given Name: _____

Preferred Name: _____

Home Address: _____

Suburb: _____ Postcode: _____

Email Address: _____

Occupation: _____

Phone: HOME: _____ WORK: _____ MOBILE: _____

Next of kin details (FAMILY MEMBER / MEDICAL POWER OF ATTORNEY)

Name: _____ Relationship to you: _____

Next of kin contact number: _____

Referring Doctor Name: _____

Address: _____

Phone: _____ Fax: _____

Usual GP Name: _____

Address: _____

Phone: _____ Fax: _____

Physiotherapist Name: _____

Address: _____

Phone: _____ Fax: _____

Other Interested Medical Practitioners: _____

Practice Details: _____

Phone: _____ Fax: _____

MEDICARE & HEALTH INSURANCE:

Medicare No: _____ Ref No: _____ Exp: ____ / ____ / ____

Private Health Insurance: Yes ☐ No ☐

Fund Name: _____ Membership No: _____

Veterans Affairs Card: Yes ☐ No ☐

Ref No: _____ White ☐ Gold ☐ Exp: _____ / _____ / _____

Public or Uninsured Patient: Yes ☐ No ☐

TAC Claim No: _____

Work Cover Claim No: _____ Insurer Name: _____

MEDICAL HISTORY & MEDICATIONS:

CARDIAC: PACEMAKERS AND OR IRREGULAR HEARTBEAT

I have had an irregular heartbeat or palpitations: Yes ☐ No ☐

Do you have a pacemaker and or defibrillator? Yes ☐ No ☐

If yes please expand: Type / Brand: _____

Do you have a Cardiologist? Yes ☐ No ☐

Cardiologist Name: _____

Cardiologist Address & Contact: _____

I have been hospitalised for a heart attack or have had heart surgery: Yes ☐ No ☐

If yes: Stent ☐ Bypass Surgery ☐ Valve ☐ (tick box for each)

BLOOD THINNING MEDICATIONS:

Do you take Asprin / Cartia? Yes ☐ No ☐ Details: _____

Do you take any of the following medications? Clopidogrel (Plavix or Iscover) ☐

Asasantin ☐ Warfarin ☐ Clexane ☐ Dabigartran (Pradaxa) ☐

Fondaparinux (Arixtra) ☐ Rivaroxiban (Xarelto) ☐ Eliquis ☐

No, I do not take any blood thinning medications ☐ Details: _____

Have you ever had a bleeding or clotting problem? Yes ☐ No ☐

Details: _____

Have you ever had a stroke or mini-stroke / TIA? Yes ☐ No ☐

Details: _____

MEDICAL HISTORY & MEDICATIONS *(cont):*

DIABETES:

Do you suffer from Diabetes? Yes ☐ No ☐ If yes: Type 1 ☐ or Type 2 ☐

Is your Diabetes controlled by: Diet ☐ Tablets/Medication ☐ Insulin Injections ☐

Do you have a Endocrinologist? Yes ☐ No ☐

Endocrinologist Name: _____

Endocrinologist Address & Contact: _____

Do you have any other specialist managing your care? Yes ☐ No ☐

Specialist Name: _____

Specialist Address & Contact: _____

CURRENT MEDICATIONS:

Please list all medications: (include aspirin, cortisone, steroids, anti-inflammatory, warfarin, herbal products and over-the-counter preparations)

Drug Name: _____ Dosage & Frequency: _____

Drug Name: _____ Dosage & Frequency: _____

Drug Name: _____ Dosage & Frequency: _____

ALLERGIES:

Do you have any allergies? (I.E. MEDICATIONS/TAPES/DRESSINGS/LATEX/CONTRAST) Yes ☐ No ☐

If yes, please list and include reaction:: _____

_____

PREVIOUS OPERATIONS:

Please list previous surgical procedures:

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

Have you ever had problems with an anaesthetic previously? Yes ☐ No ☐

If yes, please describe: _____

_____

_____

MEDICAL HISTORY & MEDICATIONS *(cont):*

BODY PART(S) INJURED/AREA OF CONCERN:

Have you ever had problems with an anaesthetic previously? Yes ☐ No ☐

Tell us briefly about yourself and your condition: _____

_____

History of Injury (E.G. FELL WHILST PLAYING SPORT): _____

_____

YOUR CURRENT SYMPTOMS

Pain: Mild ☐ Moderate ☐ Severe ☐

Pain Duration: Constant ☐ Intermittent ☐ Worse on movement ☐

Do You Experience: Swelling ☐ Weakness ☐ Numbness ☐

Normal Work/Sporting Activities: _____

What Aggravates Your Symptoms? _____

What Relieves Your Symptoms? _____

How Far Can You Walk? _____

Previous Bone or Joint Surgery: _____

Please list any specific concerns or questions you have regarding your injury/condition: _____

_____

_____

_____

CONSENT

We require your consent to collect personal information about you.
Please read this information carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We will use the information you provide in the following ways:

- Administration purposes in running our medical practice.
- Billing purposes, including compliance with Medicare, Health Insurance Commission, Workcover and Transport Accident Commission requirements.
- Disclosure to others involved in your health care, including treating doctors, physiotherapists and other specialists outside the medical practice. This may occur through referral to other doctors or for medical investigations and in the reports of results returned to us following referrals.

I have read the information above and understand the reasons why my information is to be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Patient Signature: _____ Date: _____ / _____ / _____

Name (please print) _____

CONSENT TO PARTICIPATE IN RESEARCH

I _____ am willing to participate in the collection of data for research purposes. (All data is de-indentified)

Patient Signature: _____ Date: _____ / _____ / _____

Name (please print) _____

NOTES

Have more to say? Feel free to expand here: