PATIENT REGISTRATION (NEW PATIENT FORM) **DATE:**

PLEASE ASSIST US BY FILLING IN THIS FORM AS COMPLETELY AS YOU CAN.

Name: (please circle one) Miss / Ms / Mrs / Mast / Mr / Dr or Other: _____

First: ..... Middle: .....

Surname: ..... If child, parent's name: .....

DOB: ..... **Weight**: ..... (kg) **Height**: ..... (cm) **Occupation**: .....

Address: Number & Street: .....

Suburb/Town: ..... State: …… Post Code: .....

Contact numbers (we require at least 2)

Home: ..... Work: .....

Mobile: ..... Email: .....

Alternative Contact, e.g. spouse or relative

Name: ..... Contact Number: .....

Medicare number: .....Ref. no.: ..... Exp. Date: .....

Health fund: ..... Level of cover: .....

Who referred you? : .....

Your general practitioner details:

Name: .....

Address: ..... Phone: .....

If you generally see a podiatrist please provide details:

Name: .....

Address: ..... Phone: .....

Do you see any other health care practitioners (e.g. cardiologist)?

Name: .....

Address: ..... Phone: .....

FINANCIAL RESPONSIBILITY:

I HEREBY AGREE TO PAY ALL ASSOCIATED FEES RELATING TO MY CONSULTATION/S AND/OR SURGERY, PERFORMED BY SYDNEY FOOT SURGERY (THE CENTRE FOR PODIATRIC SURGERY & MEDICINE (CPSM)).

I ACKNOWLEDGE THAT IF AN ACCOUNT IS OVERDUE, CPSM RESERVES THE RIGHT TO REFER THE ACCOUNT TO A COLLECTION AGENCY.

I AGREE TO MEET ALL REASONABLE COSTS AND COMMISSIONS INCURRED IN EMPLOYING THE SAID AGENCY TO COLLECT THE OVERDUE ACCOUNT.

I HAVE READ AND UNDERSTOOD THIS FEE ARRANGEMENT.

PATIENT SIGNATURE: …… DATE: ..... / ..... / .....

Your reason for this visit

What is your main problem?

Please list any other health practitioners you have seen for this problem.

Do you have any other foot problems? Please list.

MEDICAL HISTORY:
Please circle any of the following conditions or treatments for which you have been or are being treated.

AIDS	Anaemia	Arthritis	Asthma
Back problems	Bleeding disorders	Blood clots	Transfusions
Cancer	Gout	Heart disease	Hepatitis
High blood pressure	HIV / AIDS	Kidney disease	Low blood pressure
Liver disease	Diabetes	Neuropathy	Osteoporosis
Vascular disease	Stomach ulcer	Stroke	Thyroid disease

Other:

Are you allergic to any of the following (please circle):

Antibiotics	Adhesive tape	Latex	Local anaesthetic	Painkillers

Do you have any other major allergies:

Do you take any herbal substances? If yes (list):

Important information regarding your health and foot surgery. Please circle.

ARE YOU A SMOKER? YES / NO

HOW MANY PER DAY? _____

IF YES, ARE YOU AWARE THAT SMOKING HAS SERIOUS ADVERSE EFFECTS ON SKIN AND BONE HEALING? YES / NO

ARE YOU DIABETIC? YES / NO

WHAT IS YOUR HBA1C: _____

DO YOU TAKE INSULIN? YES / NO

WHEN WAS THE LAST TIME YOU CHECKED YOUR BSL? _____

ARE YOU TAKING ANY OF THE FOLLOWING DRUGS?

WARFARIN YES / NO

ASPIRIN YES / NO

ISCOVER YES / NO

CLOPIDOGREL YES / NO

ARE YOU TAKING ANY OF THE FOLLOWING DRUGS? (CONTINUED)

INSULIN YES / NO

METHOTREXATE YES / NO

PREDNISOLONE YES / NO

ANTI-DEPRESSANTS YES / NO

HAVE YOU EVER HAD A DEEP VEIN THROMBOSIS OR PULMONARY EMBOLISM? YES / NO

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 12 MONTHS:

ACUTE MYOCARDIAL INFARCT (HEART ATTACK) YES / NO

HAD A STENT OR PACE MAKER INSERTED? YES / NO

DO YOU HAVE STAIRS AT HOME? YES / NO	DO YOU LIVE ALONE? YES / NO **IF YES**, DO YOU HAVE SOMEONE CLOSE TO YOU THAT CAN HELP WITH YOUR RECOVERY? YES / NO
AT WORK ARE YOU MAINLY? • SEATED • STANDING / WALKING • 50/50	ARE YOU ABLE TO TAKE TIME OFF WORK AFTER SURGERY? YES / NO

SURGEON TO COMPLETE _____

SUBJECTIVE:_____

HISTORY _____

MEDICAL _____

_____

SURGICAL _____

_____

SOCIAL _____

_____

OBJECTIVE:_____

VASCULAR DP/PT

DERMATOLOGY

NEUROLOGY

ORTHOPAEDIC

BIOMECHANICAL

DIAGNOSTIC TESTING

POSSIBLE DIAGNOSIS:_____

_____

_____

PREVIOUS TREATMENTS: _____

_____

SUGGESTED TREATMENTS:_____

PROPOSED SURGERY:_____

_____

_____

SPECIAL REQUIREMENTS:_____

NOTES:_____

_____

_____

_____

_____

GA / LA DAY / O. NIGHT HOSPITAL: SDS / OTHER:

DURATION: _____ MINS