



PATIENT REGISTRATION (NEW PATIENT FORM)

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: Preferred name:

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:

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

Health fund: **Member no.:**

Level of cover:

Alternative Contact, e.g. spouse or relative:

Name: Contact Number:

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: Specialty:

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 UNDERSTAND THAT MEDICARE DOES NOT COVER ANY FEES ASSOCIATED WITH PODIATRIC TREATMENT AND/OR SURGERY.
 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 for which you have been or are being treated.

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

Are you taking any medications for any of the above conditions?

Please list:

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

Adhesive tape	Antibiotics	Latex	Local anaesthetic	Painkillers
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Do you have any other major allergies?

Do you take any herbal substances? If yes, please list:

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

<p>ARE YOU A SMOKER? YES / NO</p> <p>HOW MANY PER DAY? _____</p> <p>IF YES, ARE YOU AWARE THAT SMOKING HAS SERIOUS ADVERSE EFFECTS ON SKIN AND BONE HEALING? YES / NO</p>	<p>ARE YOU DIABETIC? YES / NO</p> <p>WHAT IS YOUR HBA1C: _____</p> <p>IF YES, DO YOU TAKE INSULIN? YES / NO</p> <p>WHEN WAS THE LAST TIME YOU CHECKED YOUR BSL? _____</p>
<p>ARE YOU TAKING ANY OF THE FOLLOWING DRUGS?</p> <p>WARFARIN YES / NO</p> <p>ASPIRIN YES / NO</p> <p>ISCOVER YES / NO</p> <p>CLOPIDOGREL YES / NO</p>	<p>ARE YOU TAKING ANY OF THE FOLLOWING DRUGS? (CONT.)</p> <p>METHOTREXATE YES / NO</p> <p>PREDNISOLONE YES / NO</p> <p>ANTI-DEPRESSANTS YES / NO</p>
<p>HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?</p> <p>DEEP VEIN THROMBOSIS OR PULMONARY EMBOLISM YES / NO</p>	<p>HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (CONT.)</p> <p>ACUTE MYOCARDIAL INFARCT (HEART ATTACK) YES / NO</p> <p>INSERTION OF A STENT OR PACEMAKER YES / NO</p>

DO YOU HAVE STAIRS AT HOME? 	Yes / No	DO YOU LIVE ALONE? IF YES, DO YOU HAVE SOMEONE CLOSE TO YOU THAT CAN HELP WITH YOUR RECOVERY?	Yes / No Yes / No
AT WORK ARE YOU MAINLY: <ul style="list-style-type: none"> • 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:

DURATION: _____ MINS