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

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

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.

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: _____

IF YES, DO YOU TAKE INSULIN? YES / NO

WHEN WAS THE LAST TIME YOU CHECKED YOUR BSL?

_____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

WARFARIN YES / NO

ASPIRIN YES / NO

ISCOVER YES / NO

CLOPIDOGREL YES / NO

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS? (CONT.)

METHOTREXATE YES / NO

PREDNISOLONE YES / NO

ANTI-DEPRESSANTS YES / NO

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

DEEP VEIN THROMBOSIS OR PULMONARY EMBOLISM YES / NO

ACUTE MYOCARDIAL INFARCT (HEART ATTACK) YES / NO

INSERTION OF A STENT OR PACEMAKER YES / NO

SOCIAL SITUATION

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

SOCIAL SITUATION (CONT.)	AT WORK ARE YOU MAINLY:
CAN YOU TAKE OFF 3-6 WEEKS FROM WORK FOR POST-SURGICAL REHABILITATION? YES / NO	• SEATED • STANDING / WALKING • 50/50

SURGEON TO COMPLETE _____

PRESENTING COMPLAINT:_____

HISTORY:_____

_____

MEDICAL:_____

_____

SURGICAL:_____

_____

SOCIAL:_____

_____

OBJECTIVE

VASCULAR: CFT DP PT BT TEMP COLOUR SKIN HAIR MESI: ABI – TBI

DERMATOLOGY: SIZE

NEUROLOGY: REFLEXES: TA KNEE PIN LIGHT TOUCH HOT/COLD NUMBNESS

ORTHOPAEDIC: POSTURE GAIT ABNORMALITIES

BIOMECHANICAL: HIP KNEE ANKLE

FOREFOOT REAR FOOT

RADIOLOGY RESULTS: _____

_____

_____

DIAGNOSTIC TESTING: _____

_____

_____

POSSIBLE DIAGNOSIS:_____

_____

_____

PREVIOUS TREATMENTS: _____

_____

SUGGESTED TREATMENTS:_____

_____

PROPOSED SURGERY:_____

_____

_____

INDICATION FOR SURGERY (VAS): _____

_____

SPECIAL REQUIREMENTS: _____

GA / LA DAY / O. NIGHT HOSPITAL: DURATION: _____ MINS