MELBOURNE ORTHOPAEDIC CLINIC

NEW PATIENT FORM

Patient Name:

Prof. Justin Hunt
Prof. Vera Maria Sallen

PATIENT DETAILS

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other **Date of Birth:** _____/_____/_____

Surname: _____ **Given Name:** _____

Known as: _____ **Height:** _____ **Weight:** _____

Home Address: _____

Suburb: _____ **Postcode:** _____

Email: _____

Occupation: _____

Telephone Numbers:

Home: _____ Work: _____ Mobile: _____

Next of kin details (family member or friend / medical power of attorney)

Name: _____ Relationship to you: _____

Next of Kin Contact number: _____

Referring Doctor: _____

Address: _____

Telephone: _____ Fax: _____

Usual GP Name: _____

Address: _____

Telephone: _____ Fax: _____

Physiotherapist: _____ Tel: _____ Fax: _____

Address: _____

Other interested Medical Practitioners: _____

Practice Details: _____

Telephone: _____ Fax: _____

MEDICARE & HEALTH INSURANCE

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Insurance: ☐ Yes ☐ No **Fund Name:** _____

Membership Number: _____

Veterans Affairs Card ☐ Yes ☐ No **No:** _____ ☐ White ☐ Gold Exp Date: _____

Public / Uninsured Patient: ☐ Yes ☐ No

FRACS Fellow of the Royal Australasian College of Surgeons
FAORTHA Fellow of the Australian Orthopaedic Association

MAIN ROOMS:
15 Erin Street
RICHMOND VIC 3121
Tel: (03) 9421 6199
Fax: (03) 9421 6114
Email: admin@moc.com.au
www.melbourneorthopaedicclinic.com.au

Patient Name:

ALLERGIES

Do you have any allergies? (ie Medications / Tapes / Dressings / Latex / Contrast) ☐ **Yes** ☐ **No**

If yes please list and include details of reaction: _____

HEART / CARDIAC CONDITIONS

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** type/brand: _____

Do you have a Cardiologist? ☐ Yes ☐ No **Cardiologist's Name**: _____

Cardiologist: Address & Contact Details: _____

I have been hospitalised for a heart attack and/or have had surgery on my heart: ☐ Yes ☐ No **If yes:** ☐ Stent ☐ Bypass Surgery ☐ Valve

BLOOD THINNERS - Anti-Clotting / Anti-Thrombotic Medications

BLOOD-THINNING MEDICATIONS

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

Do you take any of the following medications? (please tick)

☐ **Clopidogrel** *(Plavix, Iscover)* ☐ **Asasantin** ☐ **Warfarin** *(Coumadin)* ☐ **Enoxaparin** *(Clexane)* ☐ **Dabigatran** *(Pradaxa)*

☐ **Fondaparinux** *(Arixtra)* ☐ **Rivaroxaban** *(Xarelto)* ☐ **Apixaban** *(Eliquis)* ☐ **Prasugrel** *(Effient)* ☐ **Ticagrelor** *(Brilinta)*

☐ 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: _____

DIABETES

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

If Yes, is your Diabetes controlled by: ☐ **Diet Only** ☐ **Tablets/Medication** ☐ **Insulin Injections**

Do you take any of the following medications? (please tick)

Metformin Combinations: ☐ **Metformin/Empagliflozin** *(Jardiamet)* ☐ **Metformin/Dapagliflozin** *(Xigduo)*

☐ **Dapagliflozin** *(Forxiga)* ☐ **Empagliflozin** *(Jardiance)*

Do you have a Endocrinologist? ☐ Yes ☐ No **Endocrinologist's Name:** _____

Endocrinologist: Address & Contact Details: _____

Patient Name:

Do you have a Rheumatologist? ☐ Yes ☐ No **Rheumatologist's Name:** _____

Rheumatologist: Address & Contact Details: _____

_____

Do you have any additional specialists managing your care? ☐ Yes ☐ No **Name:** _____

Specialist's: Address & Contact Details: _____

_____

MEDICATIONS - Anti-inflammatory (NSAIDS) &/or Disease Modifying Drugs

Do you take any of the following medications? (please tick)

☐ **Meloxicam** *(Mobic, Moxicam)*
☐ **Piroxicam** *(Feldene)*
☐ **Celecoxib** (*Celebrex, Celaxib, Kudeq)*
☐ **Diclofenac** *(Voltaren, Fenac)*
☐ **Diflunisal** (*Dolobid)*
☐ **Sulindac** *(Aclin)*
☐ **Ketoprofen** *(Orudis, Oruvail)*
☐ **Naproxen** *(Inza)*
☐ **Ibuprofen** *(Nurofen, Rafen, Advil)*
☐ **Tofacitinib** *(Xeljanz)*
☐ **Indomethacin** *(Indocid, Arthrexin)*
☐ **Leflunomide** *(Arabloc, Arava)*
☐ **Sulfasalazine** *(Pyralin EN, Salazopyrin)*
☐ **Hydroxychloroquine** *(Plaquenil Tablets)*
☐ **Methotrexate** *(Methoblastin, Trexject)*
☐ **Injections or Infusions for Arthritis** (if yes, list name and method below)

_____

_____

ALL CURRENT MEDICATIONS &/or SUPPLEMENTS

Please list ALL medications:
(include aspirin, cortisone, steroids, anti-inflammatory, warfarin, herbal products and over-the-counter preparations, including the previously mentioned medications in this form)

Drug / Supplement name	Dosage	Frequency	Drug / Supplement name	Dosage	Frequency

ADDITIONAL NOTES: _____

_____

Patient Name:

PREVIOUS OPERATIONS

Please list previous surgical procedures: _____

Operation: _____ Year Performed: _____

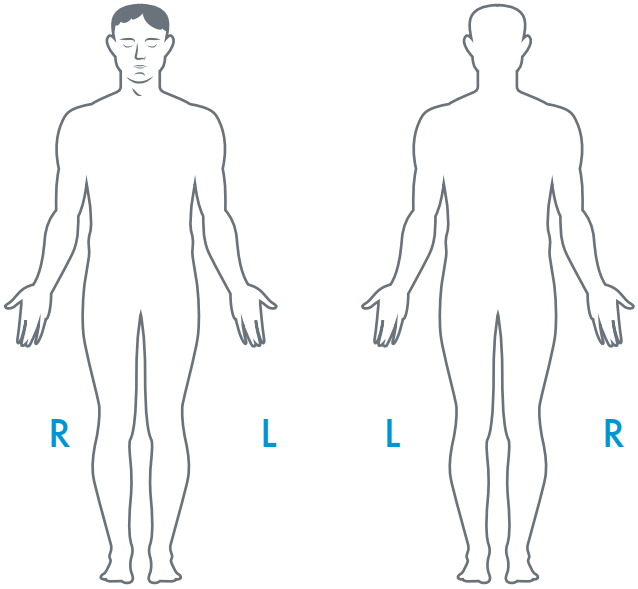
Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

Have you ever had problems with an anaesthetic previously? ☐ Yes ☐ No **If yes**, please describe: _____

BODY PART(s) INJURED / AREA of CONCERN

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 / Questions You have regarding your injury/condition:

Patient Name:

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 must 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.

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)

Signature: _____ **Date:** ___/___/_____

Name: *(Please Print)* _____

REFERRAL SOURCE

How did you hear about Us ? Referred by Doctor: ☐ GP or ☐ Specialist _____

☐ Website – www.melbourneorthopaedicclinic.com.au ☐ or Royal Australian College of Surgeons (RACS) website

☐ Google ☐ Yellow Pages ☐ White Pages ☐ Personal recommendation: _____

☐ Other: _____

PLEASE NOTE:
All Appointments, Enquiries & Correspondence to our **Richmond** Practice Only

Melbourne Orthopaedic Clinic
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RICHMOND VIC 3121

Tel: (03) 9421 6199
Fax: (03) 9421 6114
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CONSULTING AT:

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RICHMOND VIC

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Suite 3/525 McClellend Drive
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