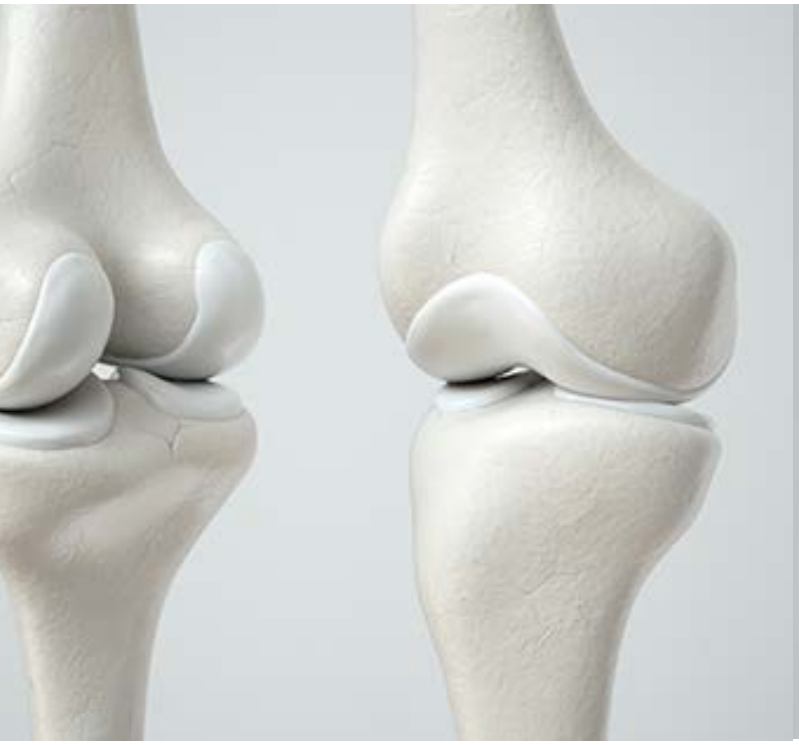
SYDNEY
ORTHOPAEDIC
CONSULTANTS

HIP REPLACEMENT | KNEE REPLACEMENT | SPORTS MEDICINE



PATIENT CARE

First Visit Form

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PATIENT CARE

First Visit Form

Please complete this form in full, by computer or by hand, printing clearly in black or blue ink.

Email your completed form to: ***drkonidarisreception@gmail.com*** *or call us on* ***02 9708 1160 with any questions***

Visit our website for more information sydneyorthopaedicconsultants.com.au

PERSONAL DETAILS			
First Name			
Last Name:			
Mr/Mrs/Ms/Miss /Dr/Prof/Other:	Date of Birth (DD/MM/YY):	Phone:	
Contact Address:			
City:		State:	Post Code:
Email:			
Occupation			
Weight and Height			
Presenting Problem			
Next of Kin	Contact No.		
REGULAR GP DETAILS			
Family Doctor	Dr Phone/Fax		
Dr Address			
REFERRING DOCTOR			
Referring Doctor	Dr Phone/Fax		
Dr Address			
ACCOUNT DETAILS			
Medicare No:	**Ref No.**	**Expiry**	
Dept. Veteran Affairs No.	Which Card? ◯ Gold ◯ White		
Private Health Fund:	**Membership No:**		

The above details are true to the best of my knowledge and permission is hereby given to release medical details to my family doctor, referring doctor or insurance company.

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MEDICAL HISTORY (PLEASE ANSWER ALL QUESTIONS)

	YES	NO		YES	NO
Heart trouble	○	○	Anaemia or other blood disorders	○	○
Chest pain	○	○	Reflux or hiatus hernia	○	○
Angina	○	○	Fits or Epilepsy	○	○
High blood pressure	○	○	Sleep Apnoea	○	○
Palpitations	○	○	Are you or could you be HIV positive?	○	○
Heart murmur or artificial valve	○	○	Bruising or swelling	○	○
Shortness of breath	○	○	Stroke	○	○
Asthma	○	○	Muscle weakness	○	○
Collapsed lung	○	○	Gall Bladder trouble	○	○
Cold or flu recently	○	○	Are you or could you be pregnant?	○	○
Cough or bronchitis	○	○	Kidney failure/stones/dialysis or infection	○	○
Cancer – type and year it was diagnosed	○	○	Liver problems – cirrhosis/jaundice/ hepatitis (A, B, C, D, E) – year diagnosed	○	○
Have you ever had blood clots?	○	○	Have you ever had a blood transfusion? – If yes what year?	○	○

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MEDICAL HISTORY - CONTINUED

Name of treating cardiologist	Contact No.
Name of respiratory physician	Contact No.
Name of Kidney Specialist	Contact No.
Name of Oncologist	Contact No.
Name of Liver Specialist	Contact No.
Any **ALLERGIES?**	Are you a **SMOKER?**
List medications:	

WORKERS COMPENSATION / THIRD PARTY DETAILS

Claim No.	Date of Injury
Employer	Insurer/Solicitor
Case Manager	Contact No.

Signature* ..... **Date** .....

* This may be provided by original or scanned signature or by electronic evidence of agreement, such as an email.

Completed forms should be returned to drkonidarisreception@gmail.com

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