PATIENT INFORMATION & CONSENT FORM - HIP

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Surname: Given Names:

Date of Birth: / / Known as:

Residential Address:

Suburb: Postcode:

Postal Address:

Phone: Home Work Mobile

Email:

I consent to receving reminders & notifications via SMS Yes ☐ No ☐
I consent to receving reminders & notifications via EMAIL Yes ☐ No ☐
I consent to receving a patient survey via EMAIL Yes ☐ No ☐

Medicare Number: Ref No [next to your name]: Expiry: /

If Patient under 18 Parent/Guardian Name: DOB: Ref No:

DVA Number: Gold ☐ White ☐ Disability:

Pension/Health Care Number: Expiry: / /

Private Health Fund Name: Fund Number: Hospital Cover: Y ☐ N ☐

Is your treatment covered under Workcover / Third Party Insurer: Y ☐ N ☐ ******Complete claim form provided***

Usual General Practioner:
[Must be completed] Suburb/Clinic:

Referring Doctor: Suburb/Clinic:

Emergency Contact Name: Phone: Relationship:

I GIVE / DO NOT GIVE consent for my Emergency Contact person listed above to communicate on my behalf with the practice about my medical care/treatment

YOUR INFORMATION & PRIVACY DISCLOSURE…

- *I agree & acknowledge my consent is required for this practice to collect/store my personal & health information, as well as to disclose information to others involved in my health care management, including treating doctors & specialists, allied health professionals outside this practice, Work Cover, Medicare & any disclosure of the medical tests or reports that are relevant to my ongoing treatment.*
- I acknowledge *No access to my medical records will be provided to any other unauthorised person or organisation i.e. solicitor, insurance companies etc. without my express written consent.*
- I agree & acknowledge that all information provided is true & correct to the best of my knowledge.
- *I agree & acknowledge that I am responsible for full payment of today's consultation fee as a private patient along with any subsequent review appointment fees (not applicable to Work cover or Third party patients, where payment has already been pre-approved/authorised)*

Patient/Guardian Signature: **Date:** / /

Please complete page 2 overleaf for advisement of your medical history etc…

Occupation: **Dominant Hand:** **Right** ☐ **Left** ☐ **Age:**

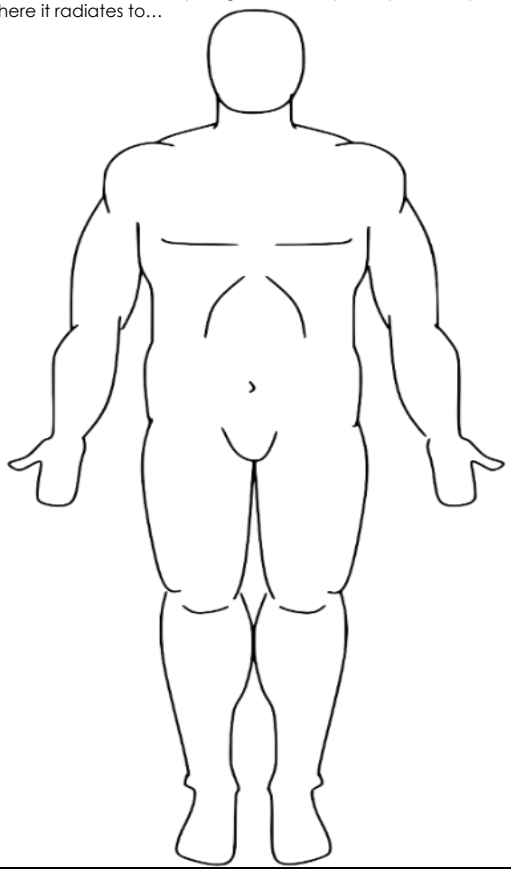
Please complete details below in regard to your complaint…

Which side are you saying Dr Graze for? RIGHT ☐ LEFT ☐ How long has it been a concern?

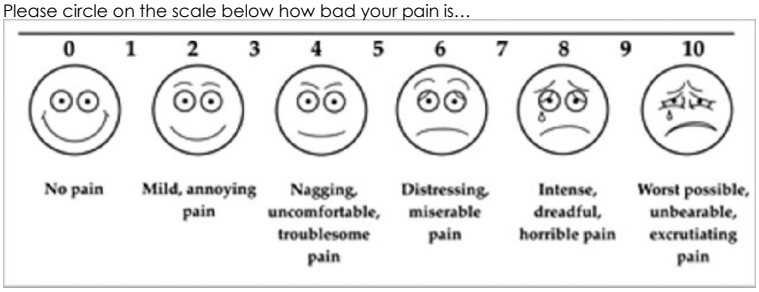
Was there an injury? Y ☐ N ☐ **What makes the pain better or worse?**

Do you experience pain? Y ☐ N ☐ Do you experience night pain? Y ☐ N ☐

Please mark on the body diagram where you experience pain & where it radiates to…



Please circle on the scale below how bad your pain is…



ASSOCIATED… Do you experience any of the following? (Please Tick)

☐ Locking ☐ Numbness ☐ Swelling ☐ Other

FUNCTION…

What is your walking limit? [Please list]

☐ Distance –

☐ Time -

How restrictive would you describe your current complaint? (Please Tick)

☐ MILD ☐ Sports (eg surfing, golf, lawn bowls, swimming, etc)

☐ MODERATE ☐ Work / Gardening

☐ SEVERE ☐ Daily self care activities [eg difficulty getting in/out of car, putting on socks/shoes]

TREATMENT… Have you had any treatment to the hip yet? (Please Tick)

☐ Pain Medication If yes, medication name:

☐ Steroid Injections If yes, how many & when:

Did they help?

☐ Physiotherapy If yes, name:

☐ Surgery If yes, details:

Please complete past medical history below as it relates to you…

☐ **DVT / PE** [EG: Clots]	☐ **DO YOU SMOKE?** ☐ **YES** ☐ **NO**
☐ Brain/Nervous System [EG: Stroke]	☐ Lung
☐ Heart/Vascular System [EG: Heart Attack, Stents]	☐ Specific Ongoing joint/ muscle/bone issues [EG: Arthritis]
☐ Urological	☐ Digestive

Previous Hospitalisation or Surgeries

PROCEDURE: DATE:

PROCEDURE: DATE:

PROCEDURE: DATE:

Family Medical History

MEDICATIONS…

Do you have any Allergies?

Y ☐ Please list N ☐

Are you taking any regular Medications?

Y ☐ Please list N ☐

Are you taking any Blood Thinners? Y ☐ N ☐

Reason for taking blood thinners *[Please Tick]*

☐ Heart Stent ☐ DVT / PE

☐ AF ☐ Stroke

☐ Other…

Which of the following blood thinners are you taking [Please Tick]

☐ APIXABAN [Eliquis] ☐ ASPIRIN

☐ CLOPIDOGREL [Plavix/Iscover] ☐ BRILINTA

☐ RIVAROXABAN [Xarelto] ☐ FISH OIL

☐ WARFARIN ☐ TURMERIC

☐ OTHER…

Do you have Diabetes? Y ☐ N ☐

Diabets Type *[Please Tick]* **Managed** *[Please Tick]*

☐ Type I ☐ Insulin

☐ Type II ☐ Oral Medication

Which of the following diabetes medications are you taking… *[Please Tick]*

☐ FORXIGA ☐ JARDIANCE ☐ STEGLATRO

☐ GLYXAMBI ☐ QTERN ☐ STEJLUJAN

☐ JARDIAMET ☐ SEGLUROMET ☐ XIGDUO

☐ OTHER…

Do you have religious beliefs that affect the use of a blood product? Y ☐ N ☐