PATIENT INFORMATION & CONSENT FORM – Knee

In order to ensure that our records are up to date, please check your personal details, medical history and details of your knee complaint below and make changes where necessary

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… **PAGE 1/2**

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

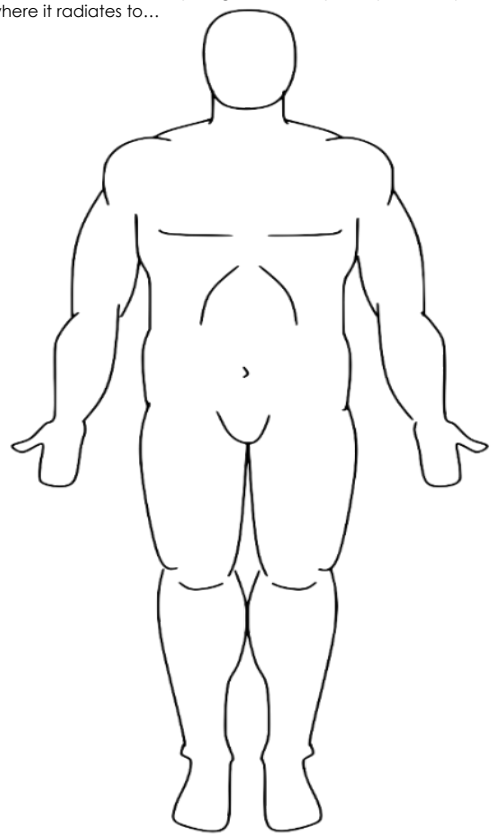
Please complete details below in regard to your complaint…

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 ☐ Swelling ☐ Giving Way

☐ Numbness ☐ 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

TREATMENT… Have you had any treatment to the knee 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 ☐