Dr Andrew Stephens
MBBS(HONS) FRACS FAOrthA
Orthopaedic Surgeon

ABN 57102319874

All correspondence: PO BOX 454 Beecroft NSW 2119 | Ph: (02) 9157 1988 | Fax: (02) 8007 0517 | Email: reception@aortho.com.au

PATIENT INFORMATION

Mr/ Mrs/ Ms/ Miss/ Master/ Other (Please circle)

Surname:_____Given Name(s) :_____Preferred :_____

Address:_____Suburb:_____Postcode:_____State:____

Home Ph:_____Work Ph:_____ Mobile:_____

contact via SMS? *(circle):* Y/N Email: _____

Date of Birth:_____ Occupation: _____

Medicare No:_____ Reference on Card:_____ Expiry Date:_____

Health Fund:_____ Membership No:_____

DVA Card No:_____ Type (Please circle): Gold/ White Card

Pension Card No:_____ Full Pension: Yes ☐ No ☐ Expiry Date:_____

Referring Doctor:_____ Please circle: Specialist/ GP

Usual GP *(if different from above)*:_____

GP Address:_____

GP Phone No:_____ GP Fax No:_____

Parent/ Guardian*(if patient 17 years and under)*:_____Contact No:_____

Medicare No:_____ Ref:____ Date of Birth:_____

Next of Kin:_____Relationship to patient:_____ Number:_____

WORKERS COMPENSATION/ MOTOR ACCIDENT CLAIMS/ OTHER: (Please indicate if applicable)

Type of Claim (please specify):_____

Employer's name:_____

Address: _____

Telephone:_____Fax:_____

Insurance Co./ Solicitor:_____

Telephone:_____Fax:_____

Date of Injury:_____ Claim No:_____

PATIENT CONSENT TO DISCLOSE INFROMATION

I have read the Privacy Act Consent information regarding the handling of my information by this Practice for the purposes set out by the Form.

As part of the course of your medical condition, it is usual to write to your referring Doctor and other Specialists to whom you may be referred to.

For all Workers Compensation, Motor Accident and Sporting Claims, it may be necessary to write to the Insurers, Employers and/or a Rehabilitation Provider.

I consent to the handling of that information subject to any limitations on access or disclosure of which I may notify this practice. Please indicate your authority to disclose this information, by signing below:

Signed:_____ Date:_____

EFAS SCORE

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Below you will find 6 questions relating to your foot and/or ankle problem. Please answer each questions by selecting the answer that best describes your situation in the last week. Each question can be answered on a 5-point scale, with descriptions given for the two endpoints of the scale. If a question does not apply to you, please indicate this by checking the N/A box on the left.

Full Name:_____ **Date of Birth:**_____

Today's Date:_____ **Operation Date (if applicable):**_____

QUESTIONS

No.	Question	Answer
1 N/A ◯	Do you have pain in your foot and/or ankle when you are at rest?	Always 0 1 2 3 Never 4
2 N/A ◯	How far can you walk before you get pain in your foot and/or ankle	Impossible 0 1 2 3 No limitation 4
3 N/A ◯	How much has your gait (i.e., the way you walk) changed because of your foot and/or ankle problem?	Extreme gait change 0 1 2 3 No change 4
4 N/A ◯	Do you have difficulty walking on uneven surfaces?	Always 0 1 2 3 Never 4
5 N/A ◯	Do you have pain in your foot and/or ankle when you are walking?	Always 0 1 2 3 Never 4
6 N/A ◯	How often do you have pain in your foot and/or ankle during physical activity?	Always 0 1 2 3 Never 4

SPORTS QUESTIONS

Please only answer these questions if you regularly engage in sports activities, if a specific question does not apply to your chosen sport, please check the N/A box.

No.	Question	Answer
S1 N/A ◯	Can you run?	Impossible 0 1 2 3 No limitation 4
S2 N/A ◯	Can you jog?	Impossible 0 1 2 3 No limitation 4
S3 N/A ◯	Do you have problems landing after jumping?	Impossible 0 1 2 3 No limitation 4
S4 N/A ◯	Are you able to perform your sports with your usual technique?	Impossible 0 1 2 3 No limitation 4

Ref: Richter M., Agren P. H., Besse L. J., Coster M., Kofoed, Maffulli N., Rosenbaum D., Steultjens M., Alvarez F., Boszczyk A., Buedts K., Guelfi M., Liszka H., Louwerens J. W., Repo P. J., Samaila E., Stephens M., Witteveen G.H.A. (2018) EFAS Score – Multilingual development and validation of a patient-reported outcome measure (PROM) by the score committee of the European Foot and Ankle Society (EFAS). Foot and Ankle Surgery, 24(3), 185-204

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PATIENT HEALTH HISTORY FORM

Social & Lifestyle History

Are you:

- ☐ A daily smoker _____cigarettes/packs smoker
- ☐ A weekly smoker _____ cigarettes/packs Smoked
- ☐ Occasional/irregular smoker _____ cigarettes/packs smoked
- ☐ Ex- smoker
- ☐ Never smoked

Do you drink alcohol?

- ☐ No, never
- ☐ Occasional
- ☐ Yes
  - Days per week _____
  - Standard drinks/day_____

Family History

Have any members of your family had:

- ☐ Deep vein thrombosis (DVT)
- ☐ Diabetes
- ☐ Asthma
- ☐ Heart disease
- ☐ Cancer
- ☐ Other

_____

- ☐ None

Allergies

- ☐ Drug allergy (please specify)_____
- ☐ Food allergy(please specify)_____
- ☐ Other (please specify):

_____

- ☐ None

Ears, Nose, Mouth, Throat

- ☐ Difficult swallowing
- ☐ Earaches
- ☐ Loss of smell/taste/hearing
- ☐ Pain when chewing
- ☐ Ringing in ear
- ☐ Sinus infection
- ☐ None

Heart and Lungs

- ☐ Pain in chest
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Other

_____

- ☐ None

Muscle/Joints/Bones

- ☐ Back pain
- ☐ Difficulty walking
- ☐ Joint pain
  Specify location: _____
- ☐ Joint stiffness or swelling
  Specify location: _____
- ☐ Muscle pain or tenderness
  Specify location: _____
- ☐ Neck pain
- ☐ None

Neurological

- ☐ Balance trouble
- ☐ Black outs/loss of consciousness
- ☐ Difficulty speaking
- ☐ Difficulty walking
- ☐ Facial drooping
- ☐ Headaches
- ☐ Injury to the brain or spine
- ☐ Light headed or dizziness
- ☐ Memory loss
- ☐ Mental confusion
- ☐ Migraines
- ☐ Mini stoke
- ☐ Neuropathy
- ☐ Numbness or tingling
- ☐ Mini stoke
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Stroke
- ☐ Tremors
- ☐ Weakness
- ☐ Other_____
- ☐ None

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ None
- ☐ Other: _____

Pulmonary

- ☐ Asthma
- ☐ Blood in cough
- ☐ Cancer
- ☐ Chronic or frequent cough
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ None
- ☐ Other:_____

Skin

- ☐ Rash or itching
- ☐ Sun sensitivity
- ☐ Hair loss
- ☐ Colour changes
- ☐ Other

_____

- ☐ None

Print full name:_____Signature: _____ Date: _____

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PATIENT PRIVACY CONSENT

Please carefully read the following information about privacy issues. A copy of this consent form will be stored in your file and you may request for a copy at any time.

The law gives you certain privacy rights regarding the information provided to this clinic. We require your consent to collect your personal information and medical history. Your attendance at the initial and subsequent appointments implies that you provide consent to disclosing, to the clinic, your health situation either for a particular event or generally. This form explains your rights regarding our use of the collected information and how we may disclose it to other medical service providers.

The information we may ask you to give us is personal. However, by refusing to provide such information restricts our ability to provide you with the standard medical care required.

We primarily collect your personal and medical information to assess, diagnose and treat your medical conditions. This enables the clinic to provide substantial support and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes including the need to manage the health care of individual patients and ensure continuity of care, to inform the patient of the health system policy and to ensure reliable and consistently high quality of care.
- Billing, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors, specialists, physiotherapists outside this medical practice who are, or may become involved in treating you. This may occur through referral to other doctors, for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to others for medical defence purposes if necessary.
- Disclosure to other doctors in the practice, locums and Registrars closely related to the practice for the purpose of patient care and teaching. **Please indicate on the privacy consent form, where indicated, if you do not want your records accessed for these purposes and we will note your record accordingly.**
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement.
- Disclosure to insurer, employer or solicitor where applicable.

I have read this form and understand why collecting of information about me is necessary. 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. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of the health care and treatment that I want.

I am aware that I have the 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 about which I notify this practice now or at any future time.

I acknowledge that I have read this form before signing it and that a member of staff of this practice has at my request, clarified any aspects of it that I did not at first understand.

I understand that I can request for a copy of this Privacy Act and Consent Information.