



New patient details:

Title: Mr Mrs Miss Ms Dr Master Other: _____

First Names: _____ Surname: _____

Preferred Name: (if any) _____ Date of Birth: ____ / ____ / ____

Phone: (H) _____ (W) _____ (M) _____

Email: _____

Address: _____

Suburb: _____ State: ____ Post Code: ____

Billing Address: _____

Next of Kin: _____ Contact Number: _____

Relationship: _____

Family Doctor: _____

Address: _____

Referring Doctor: _____

Address: _____

Physiotherapist: _____

Address: _____

Private Health Fund: _____ No: _____ Ref No: ____

Do you have? Pension card Health care card DVA Gold card DVA White card

Card No: _____ Exp: ____ / ____

Medicare No: _____ Ref: ____ Exp: ____ / ____

If the patient is under 16 years of age please provide your Medicare details below:

Parents name: _____ Ref: ____ DOB: ____ / ____ / ____

Workers compensation:

Claim no: _____ Date of Injury: ____ / ____ / ____

Insurance company: _____ Case Manger: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Employer: _____ Phone: _____

Address: _____

Privacy

Permission to Collect and Store Information:

I have read the above and agree to the collection and storage of information. I authorise Dr Mark Perko to release medical information to the Referring Doctor/GP/Physio/Insurance Company/Solicitor or the other persons nominated by me.

Signed: _____ Date: ____ / ____ / ____



Medical history:

Hand dominance: Right Left Weight: _____ Height: _____

How bad is your pain today? **0** – No pain at all - **10** – Pain as bad as it can be _____

Occupation/Job title: _____ Main duties involved: _____

What is your current work status?

Normal duties Modified duties Modified hours Student Retired

Have you had a previous fracture? No Yes *Please list:* _____

Have you had a previous surgery? No Yes *Please list:* _____

Have you ever had complications after surgery? No Yes *Please list:* _____

Have you had any previous anesthetic problems? No Yes *Please list:* _____

Has a family member had any previous anesthetic problems? No Yes *Please list:* _____

Do you take pain medication? No Yes *if yes which?* _____

Please list all other medications: _____

Blood thinners	Yes	No	Plavix/Asprin	Yes	No
High blood pressure	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Insulin	Yes	No
Sleep apnoea	Yes	No	Sleep machine	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No
Heart attack	Yes	No	Liver problems	Yes	No
Valve	Yes	No	Stomach ulcer	Yes	No
AF/Rhythm problems	Yes	No	Indigestion	Yes	No
Stroke	Yes	No	Prostate	Yes	No
DVT/Blood clots	Yes	No	Epilepsy	Yes	No
Depression	Yes	No	Thyroid	Yes	No

Do you drink alcohol? No Yes *If yes, how many days per week?* _____ *How many per day?* _____

Do you smoke? No Yes *If yes, how many days per week?* _____ *How many per day?* _____

Do you have any allergies? No Yes *Please list:* _____

Do you have any implants? No Yes Pacemaker Plate/Wires/Screws Joint replacement Breast

Other *Please list:* _____

Do you play any sports? _____

Please list past sports: _____

List the main activities that cause pain with this injury/complaint: _____

Please describe the main issue that you would like Dr Perko to address: _____



Patient self evaluation – Shoulder injuries:

Are you having pain in your shoulder? Yes No

Do you have pain in your shoulder at night? Yes No

Does your shoulder feel unstable? (As if it is going to dislocate?) Yes No

How unstable is your shoulder? **0** – Very stable **10** – Very unstable ____

Tick the number that indicates your ability to do the following activities:

Activity	Left Arm				Right Arm			
	Unable	Very difficult	Somewhat difficult	Easy to do	Unable	Very difficult	Somewhat difficult	Easy to do
Put on a coat	0	1	2	3	0	1	2	3
Sleep on your painful side	0	1	2	3	0	1	2	3
Wash back/do up bra in back	0	1	2	3	0	1	2	3
Manage toileting	0	1	2	3	0	1	2	3
Comb hair	0	1	2	3	0	1	2	3
Reach a high shelf	0	1	2	3	0	1	2	3
Lift 5kg above shoulder height	0	1	2	3	0	1	2	3
Throw a ball overhand	0	1	2	3	0	1	2	3
Do usual work	0	1	2	3	0	1	2	3
Do usual sport	0	1	2	3	0	1	2	3
	Unable	Very difficult	Somewhat difficult	Easy to do	Unable	Very difficult	Somewhat difficult	Easy to do

Thank you for completing this form.