NORTH SYDNEY ORTHOPAEDIC
& SPORTS MEDICINE CENTRE

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:

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. I understand all accounts are to be paid within 30 days of service. If accounts are not paid additional fees may may be incurred.

Signed: _____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

NORTH SYDNEY ORTHOPAEDIC & SPORTS MEDICINE CENTRE

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: _____

_____

NORTH SYDNEY ORTHOPAEDIC & SPORTS MEDICINE CENTRE

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 : ____

How would you rate your shoulder today between 1 - 100%, 100% being normal? _____

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.