DOWNLOAD and **SAVE** this form to your computer **BEFORE** you fill it in. Please follow submission instructions at the end of this form. Thank you.

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.

Please return the completed form via email to:
adminperko@nsosmc.com.au

Alternatively you can print a copy of your completed form
and bring to your appointment.