Sydney Orthopaedic Centre

PATIENT REGISTRATION FORM

YOUR SURGEONS NAME:

TITLE: FIRST NAME:

SURNAME:

ADDRESS:

EMAIL: DOB:

PHONE: (WORK) PHONE: (HOME) PHONE: (MOBILE)

MEDICARE NUMBER: EXP: REF#:

HEALTH FUND: MEMBERSHIP NO:

GP: ADDRESS:

MILITARY: (PLEASE TICK) NO: YES: PM KEYS (MILITARY ONLY)

DVA: (PLEASE TICK) WHITE CARD: WHITE CARD:

WORKCOVER: (PLEASE TICK) NO: YES:

INSURER DETAILS: CLAIM NUMBER:

OCCUPATION:

PREVIOUS SURGERY: (AS PER REFERRAL) NO: YES:

IF YES, PLEASE LIST:

CURRENT MEDICATIONS: (AS PER REFERRAL) NO: YES:

IF YES, PLEASE LIST:

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HEALTH QUESTIONNAIRE:

PLEASE TICK ANY CONDITIONS THAT YOU HAVE BEEN DIAGNOSED WITH:

HEART ATTACK	☐	PULMONARY EMBOLUS	☐	KIDNEY DISEASE	☐
HEART PROBLEMS	☐	BLEEDING OR BRUISING ISSUES	☐	RHEUMATOID ARTHRITIS	☐
RHEUMATIC FEVER	☐	HIV/ AIDS	☐	SLEEP APNOEA	☐
HIGH BLOOD PRESSURE	☐	HEPATITIS A, B OR C	☐	THYROID DISEASE	☐
STROKE	☐	ULCERS (GASTRIC, DUODENAL)	☐	OTHER:	☐
DIABETES	☐	ANAEMIA	☐		
ASTHMA	☐	CANCER	☐		
ARTHRITIS	☐	EMPHYSEMA	☐		
DEEP VEIN THROMBOSIS	☐	EPILEPSY	☐		
VARICOSE VEINS	☐	GOUT	☐		

HEIGHT: WEIGHT:

DO YOU SUFFER FROM ALLERGIES: NO: YES:

IF YES, PLEASE LIST:

DO YOU SMOKE? NO: YES:

DO YOU DRINK ALCOHOL: NO: YES:

IF YES, HOW MANY DRINK A DAY?: