

DR ANDREW M ELLIS - MBBS FRACS(Orth) FAOrthA Orthopaedic Surgeon

Title: (please circle) Dr., Mr., Mstr., Mrs. Miss, Ms. other _____ Known As: _____

Surname _____ Given Name _____

Address _____ Suburb _____

Telephone (H) _____ (W) _____ (Mob) _____

Personal email address (not business) _____

****Please note: private medical correspondence may be emailed to you**

Date of birth ____/____/____ Age _____ Occupation _____

Medicare number _____ Ref Number Next to name on card _____ Expiry date _____

Are you in a Private Health Fund? NO YES WITH HOSPITAL COVER EXTRAS ONLY

Health fund name: _____ Membership number _____

DVA Card number _____ Expiry date _____ GOLD WHITE

Pension Card number _____ Expiry date _____

Next of kin _____ Relationship _____ Phone number _____

Referring Doctor _____ Phone _____

Address _____

Usual General Practitioner _____ Phone _____

Address _____

Any other specialists that you are seeing: NAME: _____

ADDRESS/PHONE: _____

Have you had any pathology (blood tests) done? YES DATE: _____ NO

Have you had any dental work recently? YES DATE: _____ NO

I, (insert name) _____, hereby authorise Dr Andrew Ellis and his staff to obtain and/or release any relevant medical information that may be necessary and/or required to/ by other parties such as my family doctor, insurance companies or solicitors (where applicable) and I agree to take full responsibility for the prompt payment of all my accounts.

Signed _____ Date _____

Please complete the following only if applicable:

Workers Compensation Third Party Public Liability

Claim Number: _____ Insurance Company: _____

Case Manager: _____ Phone: _____

Solicitors: _____ Contact Name: _____

Ph: _____ Address: _____

FAX: _____

PATIENT HEALTH QUESTIONNAIRE

Name _____ dob / /

DATE _____

What is your: **Height** _____ cm/ ft/ins **Weight** _____ kgs /lbs

ALLERGIES		NO	YES		
Do you have allergies to medications, food, sticking plaster, latex/rubber (e.g. balloons, gloves) or other substances?				Details:	
MEDICATIONS		NO	YES		
Do you take any anticoagulant or blood-thinning therapy? (Warfarin, Coumadin, Plavix, Iscover)				Date last taken / / or still take <input type="checkbox"/> Yes	
Do you take any steroids, anti-inflammatory drugs or cortisone tablets / injections?				Name of medication: Date last taken: / /	
REGULAR MEDICATIONS not listed above	DOSE	REGULAR MEDICATIONS not listed above	DOSE		
PREVIOUS OPERATIONS / PROCEDURES					
Operation	Year	Surgeon	Operation	Year	Surgeon
Do you have, or have you had, any of the following conditions?		NO	YES		
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure				Managed by: <input type="checkbox"/> Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin	
Cancer				Site:	
Stroke				Date / /	
High blood pressure					
Heart attack / coronary / chest pain / angina (please circle)					
Palpitations / irregular heart beat / heart murmur					
Pacemaker / prosthetic heart valve / any other heart condition				Specify:	
Blood clots in a lung or leg or bleeding disorder? (You or a family member).					
Arthritis - RA or OA (please circle)					
Thyroid problems					
Liver disease / hepatitis				Specify type: A, B, C	
Kidney / bladder problems					
Hiatus hernia / gastrointestinal ulcers / bowel disorder / reflux					
Epilepsy / fits / blackouts					
Depression / dementia / other mental illness					
Migraines					
Asthma / bronchitis / pneumonia / hay fever (please circle)					
Do you have sleep apnoea?				If yes, state treatment:	
Do you ever have shortness of breath?				<input type="checkbox"/> Walking less than 50 metres <input type="checkbox"/> Climbing stairs / inclines <input type="checkbox"/> Lying flat	
Have you any wounds or breaks on your skin?					
Have you ever had MRSA or VRE?					
Have you ever been involved in a "look back" for CJD or alternatively received an "In Medical Confidence" letter notifying you of a potential exposure to CJD?					
Do you have any other conditions or infections that may require further explanation?					