Dr. Wade Harper

Patient Information Form

(Please circle one) **Mr** **Mrs** **Ms** **Miss** **Master** **Other:** __________

(PLEASE PRINT CLEARLY)

Surname: ____

Given Names: ____

Address: ____

____ **Post Code:** __________________

Date of Birth: ______________________________ **Age:** ____________

Home Phone: ______________________________ **Mobile Phone:** ___________________________

Work Phone: ______________________________ **Email:** ________________________________

Occupation: _____________________________

Medicare No: ________________________ **Reference No:** __________ **Exp Date:** _______________

Health Fund: ________________________ **Health Fund Membership No:** ______________________

DVA: ________________________ **Pension No:** _________________ **Exp Date:** _______________

Referring Doctors Name & Address: ____

____ **Post Code:** __________________

GP's Name & Address: ____

____ **Post Code:** __________________

Physiotherapist Name & Address: ____

____ **Post Code:** __________________

WORKERS COMPENSATION & THIRD PARTY PATIENTS (Compulsory)

Insurance Company Name & Address: ____

____

Claim Number: _______________________ **Case Manager:** _______________________________

Case Manager's Ph: ____________________ **Case Manager's Fax:** __________________________

Employer (if applicable): ___________________________ **Date of Injury:** ______________________

Solicitors Name & Address (if applicable): ____

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Permission is given to collect and release information on my medical history in order to provide appropriate health care, medical research and audit purposes.

I take responsibility for the payment of my accounts.

Signature:______________________________________ **Date:** ______________________

Problem area: Shoulder Elbow Other
Problem side: Left Right Both
Are you right or left handed? Right Left Ambidextrous

Main problem is? Pain / Instability / Loss of Function / Weakness / Stiffness
How long have you had symptoms? _____ weeks/ months/ years

Was there an injury? Yes No Details: ___________________________

Pain:
type - ache , sharp , burning
duration - constant , intermittent, on certain movements
severity - no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain
Interferes with sleep? Yes No
Do you need to take pain killers? No Yes ___/ day

Do you have any difficulty with; (circle)
- overhead tasks
- getting dressed
- hobbies (eg. gardening)
- driving
- doing up bra/reaching wallet
- playing sport

What treatments have you had?

Treatment	Sessions/No.	Benefit
Physiotherapy		- / nil / +
Anti-inflammatories		- / nil / +
Steroid injections		- / nil / +
Other		- / nil / +

What investigations have you had taken?
Plain XR Ultrasound CT scan MRI

Background health:
Allergies to medications:________________ What happens?________________
Regular medications:____
Circle if you take: Warfarin Steroid Aspirin Anti-inflammatory

Do you smoke? Y / N How much? ____________________
Do you drink alcohol? Y / N How much? ____________________

General medical condition: circle if you have;

Diabetes
Cancer
Stroke
Heart attack
Epilepsy
Thyroid disease
Kidney disease

Previous surgical infection
Hypertension
Asthma/Bronchitis
Hepatitis
Hiatus hernia/Ulcers
Prosthetic Heart Valve
Pacemaker
Depression/ mental illness

Previous surgery with a general anaesthetic: Y / N
Details:____