STRICTLY CONFIDENTIAL

PATIENT'S MEDICAL HISTORY

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS – *CIRCLE THE APPROPRIATE ANSWER*

PATIENT'S NAME: …………………………………………………………………………………………………..

DO YOU SMOKE: YES / NO

NUMBER OF CIGARETTES PER DAY: …………

DO YOU DRINK ALCOHOL: YES / NO

HOW MANY GLASSES PER WEEK: …………

PAST OPERATIONS:

……

……

……

ANY ANAESTHETIC PROBLEMS? YES/NO IF YES, WHAT PROBLEM ……………………………..….

ANY SERIOUS MEDICAL ILLNESSES: (e.g. ASTHMA/DIABETES/HYPERTENSION ETC)

……

……

……

HAVE YOU HAD A BLOOD TRANSFUSION? YES / NO

HAVE YOU HAD BLOOD CLOTS IN YOUR LEGS OR LUNGS? YES / NO

HAVE YOU EVER HAD A STOMACH ULCER? YES / NO

PLEASE LIST ALL MEDICATION YOU ARE TAKING
AND THE DOSAGE

………..

………..

………..

DO YOU HAVE ANY ALLERGIES? YES / NOT KNOWN WHAT? …………………………………………….

HAVE YOU HAD ANY POSSIBLE CONTACT WITH:

HEPATITIS **A**	YES / NO
HEPATITIS **B**	YES / NO
HEPATITIS **C**	YES / NO
AIDS VIRUS	YES / NO

Signature…………………………………………………………………. Date…………………………………………

CONFIDENTIAL INFORMATION

PLEASE PRINT

PATIENT'S NAME (Surname) ……………………………………….. (Given)…………………………(Middle)………………...
PARENT'S NAME (If patient under 18 years) ……………………………………………………………………………………
ADDRESS: ……………………………………………………………….. DATE OF BIRTH: ……………………………………..
……………………………………………………………………………… HOME PHONE NO: ……………………………………
……………………………………………….. P/CODE …………….. OR CONTACT NAME/PHONE …………………………..
WORK PHONE NO: ………………………………………………….. MOBILE PHONE NO. ………………………………...
OCCUPATION: ……………………………………………………….. EMAIL ADDRESS ……………………………………
MARITAL STATUS: ………………………………………………….. MEDICARE NO ……………………………………
VALID TO…………/…………..REF NO……………..
PLEASE CIRCLE YOUR METHOD OF PAYMENT: AGED PENSION NUMBER…………………………..
CASH CHEQUE EFTPOS CREDIT DVA NUMBER…………………………………………

DO YOU HAVE PRIVATE HEALTH INSURANCE: YES / NO
NAME OF HEALTH FUND……………………………………………………………………………………………………..
MEMBERSHIP NUMBER OF HEALTH FUND……………………………………………………………………………………

NAME OF REFERRING DR. ………………………………………… LOCALGP……………………………………………
DATE OF REFERRAL: ……………………………………………….

HOW DID YOU HEAR OF COASTAL ORTHOPAEDICS – Friend ☐ Ref. by GP ☐ Therapist ☐ Other…………….

WORKERS COMPENSATION

PLEASE COMPLETE THE FOLLOWING IF YOU ARE MAKING A WORKERS COMPENSATION CLAIM

EMPLOYER'S NAME ………………………………………………………………………………………………………
ADDRESS ……..
…………………………………………………P/CODE ………….. PHONE NO. ……………………………………………...
INSURANCE CO: ………
ADDRESS: ……...
…………………………………………………. P/CODE ……….. PHONE NO. ……………………………………………...
CLAIM NO. ………………………………………………………….. DATE OF INJURY ……………………………………..
CASE MANAGER ………

I HEREBY AUTHORISE COASTAL ORTHOPAEDICS TO FORWARD TO MY EMPLOYER / INSURANCE COMPANY / SOLICITOR ANY NECESSARY PARTICULARS AND/OR REPORTS.

SIGNED: ……………………………………………………………DATE: ……………………………

THIRD PARTY

SOLICITOR: ………………………………………………………… SOLICITOR'S PHONE NO…………………………………
ADDRESS: …………………………………………………………:……………………………………………………………
…………………………………………………… P/CODE ……….. DATE OF INJURY…………………………………………