# Dr Nick D Vertzyas
## Orthopaedic Surgeon

SURNAME:_____ FIRST NAME:_____Mr /Mrs /Ms /Miss /Mstr/Dr

ADDRESS:_____POSTCODE:_____

HOME PHONE:_____ WORK PHONE:_____MOBILE:_____

EMAIL:_____

DATE OF BIRTH:_____ OCCUPATION:_____WEIGHT:_____HEIGHT:_____

LOCAL/FAMILY DOCTOR:_____PHONE OR ADDRESS:_____

REFFERING DOCTOR:_____ PHONE OR ADDRESS:_____

YOUR PROBLEM (please specify):_____ ALLERGIES:_____

PRIVATE HEALTH FUND:_____ MEMBERSHIP NO:_____

DO YOU HAVE HOSPITAL COVER?:_____

MEDICARE CARD NO:_____ EXPIRY DATE:_____ REF .NO (in front of your name):_____

DO YOU HAVE AN AGED PENSION CARD? YES:_____ NO:_____ ***(please show card to reception)***

DEPT. VETERANS AFFAIRS NO:_____WHICH CARD? GOLD:_____ WHITE:_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:_____

---

**MEDICAL HISTORY (please answer all questions):**

| **Have you ever had/now have:** | **YES** | **NO** | **Have you ever had/now have:** | **YES** | **NO** |
|---|---|---|---|---|---|
| Heart trouble | | | Blood clots in (please circle) legs / lungs | | |
| Heart attack | | | Anaemia or other blood disorders | | |
| Chest pain / angina | | | Bruising or bleeding problems | | |
| | | | Do you have thalassemia? | | |
| High blood pressure | | | Indigestion or heartburn | | |
| Palpitations | | | Reflux or hiatus hernia | | |
| Heart murmur or artificial valve | | | Gall bladder trouble | | |
| Shortness of breath | | | A stroke | | |
| Asthma | | | Fits or epilepsy | | |
| Collapsed Lung | | | Muscle weakness | | |
| Have you had a cold or flu recently | | | Fainting or funny turns | | |
| Do you have a cough or bronchitis | | | Sleep apnoea | | |
| Arthritis (please circle): rheumatoid / osteo / gout / neck problems / back problems | | | Are you or could you be HIV positive? | | |
| Kidney trouble (please circle): failure / stones / dialysis / infection | | | Are you or could you be pregnant? | | |
| Diabetes-how do you control it? (please circle): diet / tablets / insulin –Year it was diagnosed:…….. | | | Have you ever had a blood transfusion? If yes, year: …….. | | |
| Cancer: type:……. Year it was diagnosed:…….. | | | Liver problems (please circle): cirrhosis / jaundice / hepatitis (A B C D E) Year it was diagnosed:…….. | | |

***THE ABOVE DETAILS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND PERMISSION IS HEREBY GIVEN TO RELEASE MEDICAL DETAILS TO MY FAMILY DOCTOR, REFERRING DOCTOR, SOLICITOR OR INSURANCE COMPANY.***

****** SIGNED*: _____ *Date:*_____