

# A/Prof Nick D Vertzyas Orthopaedic Surgeon

SURNAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ Mr /Mrs /Ms /Miss /Dr /Sir /Lady /Other \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE OR ADDRESS: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_ PHONE OR ADDRESS: \_\_\_\_\_

HAVE YOU SEEN A CARDIOLOGIST? IF YES, PLEASE WRITE THE DOCTOR'S NAME: \_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_

WHY ARE YOU SEEING DR VERTZYAS? \_\_\_\_\_

HAVE YOU HAD SURGERY ON THIS AREA? IF YES, PLEASE LIST WHAT TYPE OF SURGERY AND YEAR: \_\_\_\_\_

ARE YOU DOUBLE VACCINATED FOR COVID19? YES / NO DATE OF LAST VACCINATION: \_\_\_\_\_

HAVE YOU HAD A COVID19 BOOSTER? DATE OF BOOSTER: \_\_\_\_\_

**YOU (AND ANYONE ATTENDING THE APPOINTMENT WITH YOU) WILL NEED TO PROVIDE A VACCINATION CERTIFICATE TO OUR RECEPTION**

PLEASE LIST ALL ALLERGIES: \_\_\_\_\_

IS THIS PROBLEM RELATING TO AN INSURANCE CLAIM OR WORK RELATED INJURY? YES \_\_\_\_\_ NO \_\_\_\_\_

**\*\*Please note: This practice does not see patients in relation to insurance claims or work related injuries\*\***

PRIVATE HEALTH FUND: \_\_\_\_\_ MEMBERSHIP NO: \_\_\_\_\_ DO YOU HAVE PRIVATE HOSPITAL COVER? \_\_\_\_\_

MEDICARE CARD NO: \_\_\_\_\_ REFERENCE NUMBER (in front of your name): \_\_\_\_\_

DO YOU HAVE AN AGED PENSION CARD? (PLEASE CIRCLE) YES / NO Number: \_\_\_\_\_ *(please show card to reception)*

DEPT. VETERANS AFFAIRS NO: \_\_\_\_\_ WHICH CARD? (PLEASE CIRCLE) GOLD / WHITE

HOW DID YOU HEAR ABOUT DR VERTZYAS? \_\_\_\_\_

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 osteoporosis			Do you have thalassaemia?		
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			Sores/open wounds/ulcers on legs or feet (please circle)		
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 OR REFERRING DOCTOR.*

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

V4JAN22