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: _____

REFFERING 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: _____

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 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			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, REFERRING DOCTOR, SOLICITOR OR INSURANCE COMPANY.

***SIGNATURE*: _____ *DATE:* _____**