St Vincent's Clinic

Dr John Rooney
M.B.,B.S. (Hons), B.Sc., Ass. Dip. Pod., F.R.A.C.S., F.A.Orth.A
Orthopaedic Surgeon

PATIENT REGISTRATION FORM

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Fr ☐ Sr ☐ (Please circle)

First Name: ..... Surname: .....

Address: .....

Phone (H): ..... (W): ..... (M): .....

Date of Birth: ..... / ..... / ..... Occupation: .....

Medicare No: ☐☐☐☐☐☐☐☐☐☐ Expiry Date: ...../..... Ref No: .....

Private Health Fund: ..... Membership No: .....

Email: ..... DAN No: ..... PMKeys No. .....

Pension No: ..... DVA No: .....

Local Doctor: ..... Address: .....

Worker Compensations Y ☐ N ☐ Claim No: ..... Date of injury: .....

Insurance Co: ..... Telephone No: .....

Employers Name: ..... Telephone No: .....

PAST MEDICAL HISTORY

☐ Anaemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Emphysema
☐ Epilepsy ☐ Gout ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure ☐ Kidney Disease
☐ Rheumatoid Arthritis ☐ Sleep Apnoea ☐ Stroke ☐ Thyroid Disease ☐ Ulcers

Other: .....

Past Surgical History	Doctor	Hospital

Medications: Include Herbal Supplements	Dosage	Frequency

Allergies: .....

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Separated
Use of Alcohol	☐ Never	☐ Rarely	☐ Moderate	☐ Daily	
Smoking	☐ Never	☐ Currently ..... per day		☐ Previously, but quit, when	

Height: ..... Weight: .....

HIP

St Vincent's Clinic

HIP PROBLEM *(Please tick the relevant box)*

☐ Right ☐ Left ☐ Both *(If both, which one is worse?)* ☐ R ☐ L

What are your symptoms? .....

If an injury how did it happen? .....

.....

PAIN DESCRIPTION *(Please circle)*

Location: groin / buttock / outer Character: sharp / ache / burning Severity: 1 10

Duration: ..... Aggravated by: ..... Relieved by: .....

Does your pain wake you at night: Yes / No Any pain with stairs? Yes / No

JOINT DESCRIPTION *(Please circle)*

Stiffness: Yes / No Giving Way: Yes / No Clicking: Yes / No

CURRENT RESTRICTION *(Please tick any relevant boxes)*

☐ Shower ☐ Walking distance(how far .....) ☐ Drive a car

☐ Dressing ☐ Stairs ☐ Public Transport

☐ Shoes & Socks ☐ Getting in/out of car ☐ Walking aids

What treatment have you had for your hip?

☐ Physiotherapy ☐ Medication ☐ Injections ☐ Surgery

☐ Other .....

ALL PATIENTS TO READ & SIGN: Permission is given to collect and release information on my medical history in order to provide appropriate healthcare. In addition I understand certain information may be used in medical research and audit purposes. I understand it is my responsibility to pay my account at the time of consultation. I undertake to pay any additional expenses incurred in recovering overdue fees.

Signature: ..... Date: .....