FOOT & ANKLE

St Vincent's Clinic

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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: ....

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FOOT & ANKLE *(Please tick the relevant box)*

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

Was there an injury? ☐ Yes ☐ No Date of injury: ....

How did the injury happen? ....

....

What symptoms do you have now? ....

....

PAIN DESCRIPTION *(Please circle)*

Location: inner / outer / global Character: sharp / ache / burning Severity: 1 10

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

Does your pain wake you at night: Yes / No Pain with uneven ground: Yes / No

Numbness: Yes/No Pins & Needles: Yes/No Any pain with stairs? Yes / No

JOINT DESCRIPTION *(Please circle)*

Swelling: Yes / No Changing Shape: Yes / No Clicking: Yes / No Giving Way: 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 foot or ankle?

☐ 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: ....