

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	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated
Use of Alcohol	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Moderate	<input type="checkbox"/> Daily	
Smoking	<input type="checkbox"/> Never	<input type="checkbox"/> Currently	per day	<input type="checkbox"/> Previously, but quit, when	

Height: Weight:



HIP

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: