Dr Gawel Kulisiewicz
Orthopaedic Surgeon
MB BS, FRACS (Orth), FAOrthA

PATIENT INFORMATION

Mr Mrs Miss Ms Master Dr Other _______ Gender: ___________________________

Given Name: _______________________________ Surname: _________________________________

Known As: _______________________________ Date of Birth:________________________________

Phone: (H) _______________________ (W) ______________________ (M) ______________________

Email: ____

Street Address: ____

____ Post Code: ________________

Postal/Billing Address: (If different) ____

____

Occupation: ____

Next of Kin: _________________________ Relationship: ______________ Contact: _____________

Family Doctor: ____

Doctor's Address: ____

Referring Doctor: (If different) ____

Physiotherapist: ____

Physiotherapist's Address: ____

Medicare: __ __ __ __ __ __ __ __ __ __ __ Expiry: ___/__ Position on card: ____

Private Health Fund: ___________________________________ Number: ______________________

If the patient is under 14 years old :

Parent name________________________ D.O.B ________________ Medicare:______________No:__

Veterans' Affairs No: ____ Expiry: _________________

Military EP ID No: ____ Rank: ___________________

Aged/Disability Pension Number ____

Dr Gawel Kulisiewicz
Orthopaedic Surgeon
MB BS, FRACS (Orth), FAOrthA

Orthosports ACT

MEDICAL HISTORY

Name: ____ Height: _______ cm Weight: ______ kg

Do you suffer from any of the following medical illnesses?

Cardiac

- ☐ High blood pressure ☐ Heart Attack ☐ Heart Failure
- ☐ Angina / Chest Pain ☐ Heart Murmur ☐ Rheumatic fever
- ☐ Elevated Cholesterol ☐ Heart rhythm abnormalities
- ☐ Previous cardiac symptoms ☐ Pacemaker

Respiratory

- ☐ Asthma/Airways Disease ☐ Bronchitis ☐ Sleep Apnoea

Endocrine Issues

- ☐ Thyroid Disease ☐ Diabetes

Gastrointestinal

- ☐ Stomach Ulcers / Reflux ☐ Inflammatory Bowel Disease (Crohn's / Ulcerative colitis)
- ☐ Irritable bowel

Circulation issues

- ☐ Family history of clots ☐ Blood Clots Leg / Lung ☐ Bleeding Disorders

Rheumatological Problems

- ☐ Rheumatoid arthritis ☐ Spondyloarthropathy ☐ Other

Renal or Liver Problems ______________________

Infections

- ☐ Hepatitis B or C ☐ HIV / AIDS

Neurological Issues

- ☐ Parkinson's ☐ Stroke / TIA ☐ Epilepsy
- ☐ Migraines ☐ Other

Mental Health Issues

- ☐ Depression ☐ Anxiety ☐ Bipolar
- ☐ Other _________________________

Skin Problems

☐ Psoriasis

Other

Cancer __________________ ☐ Scoliosis ☐ Orthotics ☐ Osteoporosis

Other __________________

Do you smoke : YES / NO

Do you take any of the following:

Hormones ☐ Oral Contraceptive Pill / Implant ☐ Hormone Replacement

Blood Thinners ☐ Aspirin ☐ Plavix / Clopidogrel ☐ Xeralto ☐ Warfarin ☐ Heparin

☐ Clexane ☐ Other ______________

☐ **Anti- arrhythmic medication**

Current medications including non-prescription:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Current allergies:

_______________________________________ _______________________________________

Past operations:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Have you previously had any anaesthetic problems, or do you have a difficult airway? YES/NO

Reason for visit:

What sports or physical activities do you participate in? ____

Date of injury / Onset of problem: ___________________

Part of the body: ____ Left / Right

Dr Gawel Kulisiewicz
Orthopaedic Surgeon
MB BS, FRACS (Orth), FAOrthA

Orthosports ACT

Your consultation is in the private rooms of a private clinic

- □ I understand that full payment for consultation and consumables is required at the time of consultation unless prior documented arrangements have been made with this office.
- □ It is not the policy of this practice to bulk bill for services rendered. If you are having difficulties with payment, please discuss this with the staff prior to your appointment.
- □ I understand that I will only be notified by the doctor of any clinically relevant pathology results pertaining directly to my surgery/reason for visit.
- □ I give consent for medical information concerning myself or my child to be released to my insurer, employer, solicitor, my referring GP and other health professionals involved in my care.
- □ I give consent to the above information and any other relevant medical information being scanned and stored in my electronic patient file.

SIGNED: ____ **DATE:** _________________________________

If under 18 Parent/Guardian Responsible for Account: ____

NAME OF PATIENT/PARENT/GUARDIAN: ____

Is this, or may this be, a Workers Compensation injury? YES □ / NO □ If yes, please continue

WORKERS COMPENSATION

Date of Injury: ____

Claim Number: ____

Insurance Company: ____

Insurance Company Address: ____

Case Manager: ____

Case Manager's Phone: ____

Case Manager's Fax: ____

Name of Employer: ____

Employer's Address: ____

Employer's Phone Number: ____

I have provided the above information to the best of my knowledge and understand that I will be personally responsible for the payment of all medical fees should the cost not be approved by my insurer.

SIGNED: ____ **DATE:** __________________