FOCUS shoulder specialists

PATIENT INFORMATION SHEET

Mr/Mrs/Miss/Ms/Dr Surname:_____ Given Names:_____ DOB:_____

Address:_____ Postcode:_____ Occupation: _____

T:_____ M:_____ E:_____

Emergency contact:_____ Relationship:_____ Mobile:_____

Medicare No:_____ Expiry:____/____Your reference number on card: _____

Private health insurance: YES / NO Fund Name:_____ Member No:_____

HCC/Pension No:_____ Expires:_____/_____ Type:_____ DVA No:_____ Gold / White

Referring doctor: _____ T:_____Is this a GP ☐ or a Specialist ☐

If this is not your regular General Practitioner, please give detail: _____ T:_____

Address: _____ Postcode:_____

Physiotherapist: _____ T:_____

A:_____ E:_____

Worker's Compensation/Third Party? YES/NO (If yes, please complete Worker's Compensation/CTP section below)

WORKER'S COMPENSATON / 3RD PARTY DETAILS

Date of Injury: _____ Claim No:_____ Employer/Company Name:_____

Contact Surname: _____ Given name:_____T:_____

Employer/Company address: _____ Postcode:_____

Insurance company: _____ Insurer address:_____

Contact/Case manager details: Surname: _____ Given name:_____

Telephone: _____Email: _____

NOTE: The above details are true to the best of my knowledge and permission is hereby given to release medical details to my local doctor, solicitor or insurance company.

Signed: _____ Date: _____

Print Name: _____

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MEDICAL ALLERGY and SURGICAL HISTORY

Do you regularly take: Warfarin ☐ Plavix ☐ Aspirin ☐ or other blood thinners ☐

Details: _____

Do you regularly take: Herbal medications Yes ☐ No ☐

If so, which ones _____

Do you regularly take: Pain Medications ☐ *If so, specify type, quantity and frequency?*

_____

_____

Other current medications _____

_____

Do you drink alcohol? No ☐ Yes ☐

If yes, how many days per week do you drink? _____

How many drinks per day? _____

Do you have any allergies to DRUGS? Yes ☐ No ☐ None known ☐

If yes, which DRUGS? _____

What allergic reaction to drugs do you have? Rash ☐ Shortness of Breath ☐ Swelling ☐ Anaphylaxis ☐

☐ Other: _____

What else (apart from drugs) are you allergic to (Eg: latex, food, dust mites, cats, dogs)?

List: _____

Have you had previous orthopaedic surgery? Yes ☐ No ☐ (NB: not just on the shoulder or elbow – any type)

Have you ever had complications after surgery? Yes ☐ No ☐

What type of surgery and when? _____

_____

_____

If yes, what were the complications _____

_____

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MEDICAL HISTORY

Arthritis?

Osteoarthritis Yes ☐ No ☐

Rheumatoid Arthritis? Yes ☐ No ☐

Epilepsy Yes ☐ No ☐

If yes, do you take medication? Yes ☐ No ☐

Liver Disease?

Hepatitis B? Yes ☐ No ☐

Hepatitis C? Yes ☐ No ☐

Stroke(s)? Yes ☐ No ☐

Past Blood Transfusion? Yes ☐ No ☐

HIV/AIDS? Yes ☐ No ☐

Kidney Conditions? Yes ☐ No ☐

Gastric Problems? Yes ☐ No ☐

Indigestion / Reflux? Yes ☐ No ☐

Stomach Ulcers? Yes ☐ No ☐

Venous Conditions? Yes ☐ No ☐

DVT (Thrombosis)? Yes ☐ No ☐

Varicose Veins? Yes ☐ No ☐

Thyroid conditions

Hyper-active? Yes ☐ No ☐

Hypo-active? Yes ☐ No ☐

Cardiac Problems

Heart Attack Yes ☐ No ☐

High Blood Pressure Yes ☐ No ☐

Low Blood Pressure Yes ☐ No ☐

Other? _____

Diabetes? Yes ☐ No ☐

If yes, how is it controlled? Tablets ☐ Insulin ☐ Diet ☐

Lung Conditions

Asthma? Yes ☐ No ☐

Emphysema? Yes ☐ No ☐

Sleep Apnoea? Yes ☐ No ☐

Pulmonary Embolus? Yes ☐ No ☐

Are you a smoker? Yes ☐ Never ☐ Quit ☐

Cancer?

Breast? Yes ☐ No ☐

Mastectomy? Yes ☐ No ☐

Shoulder Region? Yes ☐ No ☐

Other: _____

Issues with Other Joints Yes ☐ No ☐

If yes, which ones? _____

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SHOULDER SYMPTOMS

Which shoulder is it? Left ☐ Right ☐ Both ☐

Hand Dominance Left ☐ Right ☐ Both ☐

When did symptoms start? ____/____/____(approx)

Did symptoms start: Suddenly ☐ Gradually ☐

From an injury? Yes ☐ No ☐ Unsure ☐

If yes, when was the injury ____/____/____(approx)

Injury type: Sport ☐ Fall ☐ Car Accident ☐

Bicycle Accident ☐ Motorbike Accident ☐

Work Accident ☐ OR Repetitive Injury ☐

Or another injury or accident: _____

Do you, or have you had any shoulder:

Weakness? Yes ☐ No ☐

Dislocations? Yes ☐ No ☐

If yes, how many have you had? _____

Do you experience any shoulder stiffness? Yes ☐ No ☐

To treat your symptoms have you had any:

Physiotherapy? Yes ☐ No ☐

Injections? Yes ☐ No ☐

How many Physio appointments _____

How many Injections _____

Previous surgeries? Yes ☐ No ☐

If yes, when? _____

Type / Name? _____

Other Treatment? Yes ☐ No ☐

If yes, describe briefly? _____

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THE AMERICAN SHOULDER & ELBOW SOCIETY RATING SCALE

If 0 = no pain and 10 = the worst pain, how bad is your pain today out of 10? _____

Tick the box next to the number that indicates your ability to do the activity normally (i.e. not just today), complete details for both shoulders please. *Note: 0 = unable to do and 3 = easy to do*

	Left shoulder				Right shoulder			
	Unable	Very difficult	A bit difficult	Easy to do	Unable	Very difficult	A bit difficult	Easy to do
Put on a coat	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Sleep on your side	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Wash your back or do up your bra	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Manage toileting	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Comb hair (if bald, do the action)	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Reach a high shelf	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Lift 5kgs or 10lbs above the shoulder	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Throw a ball overhand	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Do your usual work or activities	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐
Do your usual sport or leisure activity	0☐	1☐	2☐	3☐	0☐	1☐	2☐	3☐

1. Are you having pain in your shoulder? Yes☐ No☐
2. Do you have pain in your shoulder at night? Yes☐ No☐
3. Do you take pain medication (Eg, Panadol, Nurofen, Aspirin etc.)? Yes☐ No☐
4. Do you take narcotic medication (Eg, Panadine, Nurofen Plus or stronger? Yes☐ No☐
5. How many tablets would you take each day (on average) just for your shoulder? Yes☐ No☐
6. Does your shoulder feel unstable (i.e. as if it is going to dislocate)? Yes☐ No☐
7. If 0 = not at all and 10 = unstable, how unstable does your shoulder feel today? 0 1 2 3 4 5 6 7 8 9 10

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

- Administrative purposes for operating our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you. If you would like to see the detailed consent, please advise one of the administrative staff.

Medicare partially covers the cost of your consultation. The full consultation fee is payable in on the day the consultation. The Medicare rebate can then be claimed back.

Type of consult	Fee	Medicare rebate
Initial consult	$220.00	$76.15
Follow up consult	$95.00	$38.25
Second Opinion	$330.00	$76.15

Note: The 2 week and 6 week appointments post-surgery are included in the surgical fee. Appointments after 6 weeks are considered Follow-up appointments.

Signed: _____ Date: _____

Patient Name (Please print): _____