# Patient
## Information Form

FOCUS shoulder specialists

| Patient Details | | | |
|---|---|---|---|
| Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (please specify) ☐ | | | |
| Given names: | Surname: | | |
| Residential address: | | Postcode: | |
| Postal address (if different from above): | | Postcode: | |
| Date of birth (dd/mm/yyyy): | Email: | | |
| Occupation: | | | |
| Mobile | Home phone: | | |
| Emergency contact person: | Relationship: | Emergency contact phone: | |
| Medicare card number: ☐☐☐☐☐☐☐☐☐☐ ☐ | | Medicare card person ID: | |
| Private health cover: Yes ☐ No ☐ | Health fund: | Member number: | |
| HCC/Pension Number: | Expiry: / | Type: | DVD No: Gold ☐ White ☐ |
| How did you hear about us:<br>Doctor/Specialist ☐ Workcover manager ☐ Another patient ☐ Family/friend ☐ Physio ☐<br>Google ☐ Facebook ☐ Instagram ☐ Hospital Staff ☐ Signage ☐ | | | |
| How did your injury occur: | | | |

| Referring Doctor Details | | |
|---|---|---|
| Referring doctor's name: | GP ☐ Specialist ☐ | |
| Referring doctor's clinic/address: | Phone: | |
| **General Doctor Details** | | |
| Regular GP's name (if different from above): | | |
| Regular GP's clinic/address: | Phone: | |
| **Physiotherapy Details** | | |
| Physiotherapist's name (if any): | Phone: | |
| Physiotherapist clinic/address: | | |

| Worker's Compensation/3rd Party Details (if applicable) | | |
|---|---|---|
| Claim number: | Date of injury: | |
| Your workplace/company name: | | |
| Address of your workplace: | | |
| Contact person at your workplace: Given name: | Surname: | Phone: |
| **Workcover Insurance Details** (if applicable) | | |
| Insurance company name: | | |
| Insurance company address: | | |
| Insurance company case manager: Given name: | Surname: | Phone: |
| Case manager's email address: | | |

| Patient Declaration (required, please tick) |
|---|
| ☐ The information I have provided is accurate and complete, to the best of my knowledge. |
| ☐ I give permission to release medical details to my doctor, solicitor, or insurance company. |
| ☐ I give permission for x-rays and imaging may to be shared with our online community for educational purposes. |

**Signature:** _____ **Date:** _____

**Patient Name:** _____

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| Medications and Allergies | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Do you regularly take blond thinners: Warfarin ☐ Plavix ☐ Aspirin ☐ Xarelto ☐ other ☐ | | | | | | | | |
| *Details:* | | | | | | | | |
| Do you regularly take herbal medications: Yes ☐ No ☐ | | | | | | | | |
| *Details:* | | | | | | | | |
| Do you regularly take pain medications: Yes ☐ No ☐ | | | | | | | | |
| *If so, specify type, quantity, and frequency:* | | | | | | | | |
| Any 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 ☐ Not sure ☐ | | | | | | | | |
| *If yes, which drugs:* | | | | | | | | |
| What allergic reaction to drugs do you have: Rash ☐ Shortness of Breath ☐ Swelling ☐ Anaphylaxis ☐ | | | | | | | | |
| ☐ Other ☐ None | | | | | | | | |
| What else (apart from drugs) are you allergic to, e.g. latex, food, dust mites, cats, dogs: | | | | | | | | |
| *Details:* | | | | | | | | |
| **MRI Safety Questions** | | | | | | | | |
| Do you suffer claustrophobia: Yes ☐ No ☐ | | | | | | Do you have a pacemaker: Yes ☐ No ☐ | | |
| Do you have any metal in the body, e.g., pins, plates, rods, screws, nails, clips: Yes ☐ No ☐ | | | | | | | | |
| Have you had any head, heart, eye, or ear surgery: Yes ☐ No ☐ | | | | | | | | |
| **Surgical History** | | | | | | | | |
| Have you had any previous orthopaedic surgery: Yes ☐ No ☐ | | | | | | | | |
| *If yes, what type of surgery and when:* | | | | | | | | |
| | | | | | | | | |
| Have you ever had complications after surgery: Yes ☐ No ☐ | | | | | | | | |
| *If yes, what were the complications:* | | | | | | | | |
| **Medical History** | | | | | | | | |
| ***Arthritis:*** | | | ***Liver Disease:*** | | | ***Lung Conditions:*** | | |
| Osteoarthritis | Yes ☐ | No ☐ | Hepatitis B | Yes ☐ | No ☐ | Asthma | Yes ☐ | No ☐ |
| Rheumatoid Arthritis | Yes ☐ | No ☐ | Hepatitis C | Yes ☐ | No ☐ | Emphysema | Yes ☐ | No ☐ |
| ***Epilepsy:*** | Yes ☐ | No ☐ | Stroke(s) | Yes ☐ | No ☐ | Sleep Apnoea | Yes ☐ | No ☐ |
| *If yes, do you take medication?* | | | Past Blood Transfusion | Yes ☐ | No ☐ | Pulmonary Embolus | Yes ☐ | No ☐ |
| | | | HIV/AIDS? | Yes ☐ | No ☐ | Are you a smoker | Yes ☐ | No ☐ |
| ***Thyroid Conditions:*** | | | Kidney Conditions | Yes ☐ | No ☐ | ***Cancer:*** | | |
| Hyper-active | Yes ☐ | No ☐ | Gastric Problems | Yes ☐ | No ☐ | Breast | Yes ☐ | No ☐ |
| Hypo-active | Yes ☐ | No ☐ | Indigestion/Reflux | Yes ☐ | No ☐ | Mastectomy | Yes ☐ | No ☐ |
| ***Cardiac Problems:*** | | | Stomach Ulcers | Yes ☐ | No ☐ | Shoulder region | Yes ☐ | No ☐ |
| Heart Attack | Yes ☐ | No ☐ | Venous Conditions | Yes ☐ | No ☐ | Other : | | |
| High Blood Pressure | Yes ☐ | No ☐ | DVT (Thrombosis) | Yes ☐ | No ☐ | ***Diabetes:*** | Yes ☐ | No ☐ |
| Low Blood Pressure | Yes ☐ | No ☐ | Varicose Veins | Yes ☐ | No ☐ | Management: | | Tablets ☐ |
| Other : | | | ***Other joint concerns:*** | Yes ☐ | No ☐ | | | Insulin ☐ |
| | | | Details: | | | | | Diet ☐ |

# Patient
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FOCUS shoulder specialists

| Shoulder Symptoms | | |
|---|---|---|
| Which shoulder is it: Left ☐ Right ☐ Both ☐ | | |
| Hand Dominance: Left ☐ Right ☐ Both ☐ | | |
| Do you experience any shoulder stiffness: Yes ☐ No ☐ | | |
| Have you experienced any shoulder weakness? Yes ☐ No ☐ | | |
| When did symptoms start: (MM/YYYY) | Did symptoms start: Suddenly ☐ Gradually ☐ | |
| Did symptoms start as a result of an injury: Yes ☐ No ☐ Unsure ☐ | *If yes, date of injury:* | |
| Injury type: Sport ☐ Fall ☐ Car Accident ☐ Bicycle Accident ☐ Motorbike Accident ☐ Work Accident ☐ Repetitive Injury ☐ | | |
| To treat your symptoms have you had any: | | |
| Physiotherapy? Yes ☐ No ☐ | *How many physio appointments:* | |
| Injections? Yes ☐ No ☐ | *How many injections:* | |
| Other Treatment? Yes ☐ No ☐ | *Details:* | |
| Previous surgeries? Yes ☐ No ☐ | *If yes, when:* | |
| Have you had any shoulder dislocations? Yes ☐ No ☐ | *How many:* | |

| 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 <u>both</u> 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 ☐ |
| Do your usual sport or leisure activity | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |

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

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## 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.
- X-rays, imaging, and photographs may be shared with our online community for educational purposes. We take great care to protect patient privacy and will not disclose any identifying information. If you are a patient and do not wish for your medical information to be used in this way, please inform us immediately so that we can respect your wishes. Our primary goal is to provide education and training for healthcare professionals, and we thank you for your understanding.

Please be advised of our consultation fees:

| | Consultation Fee | Medicare Rebate |
|---|---|---|
| Initial consult | $280.00 | $78.05 |
| Initial consult (fracture) | $310.00 | $78.05 |
| Follow up consult | $95.00 | $39.25 |
| Second opinion | $360.00 | $78.05 |

*Please note, the full consultation fee is payable on the day of the consultation.*

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

Sign: _____ Date: _____

Patient Name (Please print): _____