Dr David Drynan

*Adult and Paediatric Shoulder, Elbow and Knee Surgeon*

**Registration form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please complete the form and bring it to your appointment or email to [reception@drdaviddrynan.com.au](mailto:reception@drdaviddrynan.com.au) | | | | | | | | | | | | | | |
|  Mr. Mrs. Miss  Ms. Mast  Patient’s First name: | | | | Last name: | | | | | | | | Birth date:  / / | Age: | |
|  | | | | | | | | | | | |
| Home Phone | | | | | Mobile phone no: | | | | | | | □ Opt out of SMS appointment reminders | | |
| Email: | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | |  | | |
| Street Address: | | | | | | | | | | | |  | | |
| P.O. Box: | | Suburb: | | | | | | State: | | | | Post Code: | | |
|  | |  | | | | | |  | | | |  | | |
| Occupation: | | Treatment area including side: | | | | | | Height: | | | | Weight: | | |
|  | |  | | |
| Next of Kin: | | | | | | | Relationship: | | | | | Phone | | |
| Referring Doctor: (name, address + Ph) | | | | | | | | | | | | | | |
| General Practitioner: (name, address + Ph) | | | | | | | | | | | | | | |
| Physiotherapist: (name, address + Ph) | | | | | | | | | | | | | | |
| Medicare No: | | | | | | Ref No: | | | | Exp date: | | | | |
| Private Health Insurance | | | | | | No: | | | | | | | | |
| Pension Type | | | | | | No: | | | | | | | | |
| Veterans No: | | | | | |  | | | | | | | | |
| Are you making a claim for Compensation? Yes / No | | | | | | Date of Injury: | | | | | | | | |
| □ Workers Compensation | | | □ CTP | | | □ Personal Injury Claim | | | | □ Public Liability | | □ Sports Insurance | | |
| Claim Number: | | | | | | Insurer: | | | | | | | | |
| Case Manager Name | | | | | | | | | | Phone Contact | | | | |
| Insurers postal address:  Insurers email: | | | | | | | | | | | | | | |
| **Declaration**:  I give permission for correspondence to be sent to my referring doctor, general practitioner, physiotherapist and insurance company where appropriate.  I give permission for Dr Drynan to hold clinical information regarding my condition for the use in optimising care.  I give permission for Dr Drynan to use deidentified data, scores and clinical photographs for research and educational purposes.  I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.  I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal cost incurred | | | | | | | | | | | | | | |
|  |  | | | | | | | |  | |  | | |  |
|  | Patient/Guardian signature | | | | | | | |  | | Date | | |  |
|  | Name (please print): | | | | | | | |  | |  | | |  |
|  |  | | | | | | | | | | | | |  |

**Medical History:**

**Have you ever been diagnosed with:**

|  |  |  |  |
| --- | --- | --- | --- |
| Heart attack | Yes No | Depression | Yes No |
| Angina | Yes No | Anxiety | Yes No |
| Pulmonary embolism | Yes No | Any other mental health diagnosis | Yes No |
| Clot in leg – DVT | Yes No | Congenital conditions | Yes No |
| Emphysema/COPD | Yes No | HIV/Hep C/Hep B | Yes No |
| Cancer | Yes No | Do you smoke? | Yes No |
| Diabetes Type I/II | Yes No | Do you drink Alcohol on daily basis? | Yes No |

**Past medical and surgical history:**

*Please list below, if you need more space, or after a second opinion, please bring specialist letters with you to the consultation.*

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis or Operation | Year Diagnosed or Operated | Under the care of specialist, Contact information if available | Ongoing treatment of condition. *(Example – Aspirin for treatment)* |
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|  |  |  |  |
|  |  |  |  |
| ANY ANAESTHETIC CONCERNS WITH OPERATIONS | |  | |

**Current Medications:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Dose** | **Frequency** | **Name** | **Dose** | **Frequency** |
|  |  |  |  |  |  |
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**Please list Allergies:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergy** | **Reaction** | **Allergy** | **Reaction** |
|  |  |  |  |
|  |  |  |  |

**Upper Extremity Questions:**

What side is the issue?

Did you injury yourself – how?

Is this a work related injury?

Do you have shoulder stiffness?

Do you have shoulder weakness?

Do you have altered sensation in your hands or arm?

Have you had a shoulder dislocation?

Have you had injections? Where? How many? Did they work?

Have to trialled physio therapy?

Have you had a shoulder or elbow operation?

Do you have elbow weakness?

Do you have stiffness of the elbow?

Do you have any spine, abdominal or lower limb orthopaedic conditions?

Do you want to return to sport? If so, what sport and what level?

**Knee Questions:**

What side is the issue?

Dis you injure yourself? How?

Is this a work related injury?

Do you have knee stiffness?

Do you have knee instability? – have you lost confidence in your knee?

Does your knee swell?

Do you have night pain?

Do you want to return to sport? If so what and at what level?

*This is data is collected to assist your clinical care and communication with other health care providers.*