**This Document is Confidential**

# NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MARITAL STATUS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MEDICARE NO:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENTS NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **EXP. DATE:**\_\_\_\_\_\_\_ **NO. ON CARD:\_\_\_\_\_\_\_\_**

**(If under 18 years of age)**

**CONTACT PERSON:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **VETERANS No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship** \_\_\_\_\_\_\_\_\_\_\_**Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIVATE HEALTH INSURANCE: YES / NO**

**FUND NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FUND NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF CONTRIBUTOR:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE PAID TO:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING DOCTOR:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## DATE OF REFERRAL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCAL GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF INJURY/ONSET OF PROBLEM:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SITE OF PROBLEM (HIP, KNEE, SHOULDER ETC):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## HOW DID IT HAPPEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### WORKERS COMPENSATION/THIRD PARTY

## WORKERS COMPENSATION: YES / NO THIRD PARTY: YES / NO

**Employer:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **InsuranceCompany:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Solicitor:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone No:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Claim No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Accident:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU:**

**Smoke YES/NO** If YES, How much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Drink Alcohol YES/NO If YES, How much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have any known allergies** Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Have you had any previous operations/surgery? YES/NO Please list with approx date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you had any anaesthetic problems? YES/NO**

**Describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you/have you ever suffered from any of the following?**

**\* CARDIOVASCULAR PROBLEMS (heart and circulation) YES / NO**

**Please tick:**

**Blood pressure** \_\_\_\_\_\_\_\_\_\_

**Heart attack** \_\_\_\_\_\_\_\_\_\_

**Angina** \_\_\_\_\_\_\_\_\_\_

**Stroke** \_\_\_\_\_\_\_\_\_\_ **Circulatory** \_\_\_\_\_\_\_\_\_\_

**Thrombosis (DVT)** \_\_\_\_\_\_\_\_

**Other** \_\_\_\_\_\_\_\_\_\_

#### \* LUNG/RESPIRATORY (i.e. chest) YES / NO

**Please tick:**

**Asthma** \_\_\_\_\_\_\_\_\_\_

**Chronic bronchitis** \_\_\_\_\_\_\_\_

**Other** \_\_\_\_\_\_\_\_\_\_

#### \* PREVIOUS OR CURRENT CHRONIC INFECTION YES / NO

**Please tick:**

**TB**\_\_\_\_\_\_\_\_\_\_

**Hepatitis A B C**\_\_\_\_\_\_\_\_\_\_

**HIV**\_\_\_\_\_\_\_\_\_\_

**\* CHRONIC JOINT PROBLEMS YES / NO**

**Please tick:**

**Rheumatoid arthritis**\_\_\_\_\_\_

**Gout**\_\_\_\_\_\_\_\_\_\_

**Other**\_\_\_\_\_\_\_\_\_\_

#### \* DIABETES YES / NO

**\* OTHER MEDICAL ILLNESS Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE LIST ALL MEDICATIONS CURRENTLY TAKEN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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