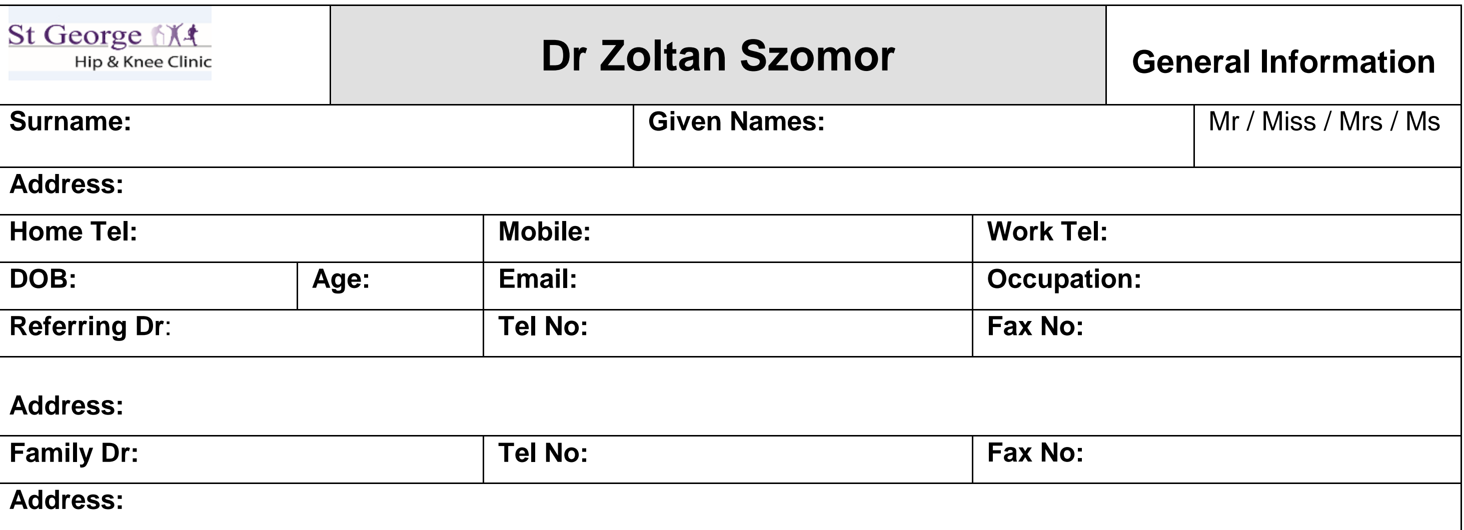

St George Hip & Knee Clinic	**Dr Zoltan Szomor**	**General Information**

Surname:	**Given Names:**	Mr / Miss / Mrs / Ms
Address:		

Home Tel:		**Mobile:**	**Work Tel:**
DOB:	**Age:**	**Email:**	**Occupation:**
Referring Dr:		**Tel No:**	**Fax No:**
Address:			
Family Dr:		**Tel No:**	**Fax No:**
Address:			

Medicare No:	**Valid to:**	**Reference No:**
Veterans Affairs No:	**Pension No:**	
Health Fund:	**Membership No:**	
Next of Kin:	**Relationship:**	**Tel No:**

Workers Compensation Details (if appropriate)		
Insurance Co:	Tel No:	Fax No:
Claim No:	Case Manager:	
Employer:	Contact Name:	Tel No:

MEDICAL HISTORY – Please circle if you have ever had any of the following:

Heart Trouble High Blood Pressure. Shortness of breath. Stoke. Epilepsy. Hay fever / sinusitis.

Depression: Indigestion / Ulcers. Rheumatic Fever. Hepatitis. Diabetes. Asthma.

Cancer (describe where and year): Any other serious illness:

Allergies (Please name):	Yes	No
Do you smoke. If so how many per day:	Yes	No
Do you drink alcohol. If yes how many per day:	Yes	No
Any complications post surgery: If yes describe:	Yes	No
Are you pregnant. If so how many weeks:	Yes	No

Please list current medications including Aspirin:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list previous surgeries and year:	
1.	4.
2.	5.
3.	6.

Height:	**Weight:**	**BMI:**

ALL PATIENTS TO READ AND SIGN:

Permission is given to collect and release information regarding my medical history in order to provide appropriate healthcare. In addition I understand certain information may be used for medical research or audit purposes. I understand that it is my responsibility to pay my account at the time of consultation. I undertake to pay any additional expenses incurred in recovering overdue fees.

Signed:

File 2019

HISTORY OF PRESENTING PROBLEM – TO BE COMPLETED BY THE PATIENT

Problem area:			Left	Right
Was there an injury?	No	If Yes, when:	If yes, is it work related?	

If an injury, how did it happen?

If not an injury when this problem first bother you?

What symptoms did you first notice?

☐ Pain: Mild / Moderate / Severe	☐ Difficulty Squatting
☐ Swelling: Mild / Moderate / Severe	☐ Difficulty Kneeling
☐ Stiffness: Mild / Moderate / Severe	☐ Difficulty with Stairs: Up / Down
☐ Instability / Giving Way	☐ Difficulty with a Car: Getting In / Getting Out
☐ Clicking: ☐ Locking:	☐ Difficulty getting up from a sitting position

Current restrictions:

Have you had similar problems in the past? If so please describe.

What treatment have you had? (please circle)

Physiotherapy. Anti-inflammatory medications: Pain Killers. Cortisone Injections.

Surgery for this injury (add details):

Sports and Leisure (this includes walking or gardening):

Would you like a copy to go to your Physiotherapist, Cardiologist or Neurologist.
If yes name & suburb