



New Patient Details

Your Title: Mr [] Mrs [] Ms [] Miss [] Master [] Dr [] Other: _____

First (given) Names*: _____ Surname*: _____
*must be the same as they appear on your Medicare card if you have one

Preferred Name (if any): _____ Date of Birth: ____/____/____ Age: ____ Gender: Male [] Female []

Address: _____ Mobile Ph: _____

Suburb: _____ Home Ph: _____ Work Ph: _____

State: _____ Postcode: _____ Email: _____ @ _____

Account to be sent to (ie parent's name if patient is a child): _____

Next of kin: _____ (required by law) Next of kin's mobile number: _____

What is your next of kin's relationship to you?: _____

Medicare Number: _____ Your Ref No on the card: _____ Expiry date: ____/____/____

Private Health Fund: _____ Membership No: _____

Please tick if you have a: Pension card [] Health Care card [] Gold DVA card [] or a White DVA card []

Card number for the above: _____ What is the card's expiry date?: ____/____/____

Name of referring doctor: _____ Is this doctor is a: GP [] or a Specialist []?

The name of your usual GP (general practitioner) if different from above: _____

GP's address: _____ Phone: _____

Physiotherapist: _____ Phone: _____

Physiotherapist's address: _____

Are you retired? Yes [] Semi-retired [] No [] What is (or was) your occupation? _____

Competitive Sports you play: _____ Other sports: _____

Will your consultation be related to a claim for Workers Compensation? YES [] NO []? If you answered YES, please complete:

Workers Compensation Claims ONLY

Date of Injury: ____/____/____ Employer's name (company): _____ Phone: _____

Employer's address: _____ Fax or email: _____

Insurance Company: _____ Claim Number (if known): _____

Insurance Company's address: _____ Fax or email: _____

Case Manager's name: _____ Phone (direct number): _____

Case Manager's email address: _____ @ _____

*While Sydney Shoulder Specialists take every precaution to ensure files are safe to download they cannot accept liability for any interference with or damage to your computer system, software or data occurring in connection with or relating to this form or its use. Your own adequate computer system, software and data protection are essential.

Medication, Allergy and Surgical History

Are you taking **blood thinners**? No Yes - if yes, which? Warfarin Plavix Aspirin other : _____

Do you regularly take **pain** medications? No Yes - if yes which ones? _____

Do you take any **herbal** medications? No Yes - if yes which ones? _____

Are there any other current or regular medications that you take? _____

Do you drink **alcohol**? No Yes - if yes, how many days per week usually? ____ & how many drinks on those days usually? ____

Do you have any **allergies to DRUGS**? No Unknown Yes - 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, grass)? _____

What allergic reaction to these things do you have? Rash Shortness of Breath Swelling Anaphylaxis other : _____

Have you had any **previous surgery (not just upper limb)**? No Yes If yes - what type and when? _____

Have you ever had **complications** after surgery? No Yes If yes - what complications? _____

Medical History

Arthritis

Osteoarthritis? No Yes

Rheumatoid Arthritis? No Yes

Diabetes? No Yes

If Yes, how is it controlled? by Tablet Insulin Diet

Epilepsy? No Yes

If Yes, do you take medication? No Yes

Liver Disease

Hepatitis B? No Yes

Hepatitis C? No Yes

Stroke(s)? No Yes

Past Blood Transfusions? No Yes

HIV / AIDS? No Yes

Kidney Conditions? No Yes

Gastric Problems

Indigestion / Reflux? No Yes

Stomach Ulcers? No Yes

Venous Conditions

DVT (Thrombosis)? No Yes

Varicose Veins? No Yes

Thyroid Conditions

Hyper-active thyroid? No Yes

Hypo-active thyroid? No Yes

Cardiac Problems

Heart Attack? No Yes

High Blood Pressure? No Yes

Low Blood Pressure? No Yes

Other? _____

Lung Conditions

Asthma? No Yes

Emphysema? No Yes

Sleep Apnoea? No Yes

Pulmonary Embolus? No Yes

Are you a smoker? Never Quit Yes

Cancer

Breast? No Yes

Mastectomy? No Yes

Shoulder or Elbow Region? No Yes

Other? _____

Any problems with other joints? No Yes

If yes, which? _____

Shoulder Symptoms

Which shoulder is it? Left Right or both sides

Hand dominance? Left Right or ambidextrous

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

Did they start **suddenly**? or develop gradually?

Were they from an **injury**? No Yes or unsure

If Yes, when was the injury? ____/____/____ (approx is OK)

What **type of injury**? sports a fall car accident

bicycle accident motorbike accident

work accident or a repetitive injury

or another accident : _____

Do you have now or have you had any shoulder:

Stiffness? No Yes

Do you have now or have you had any shoulder:

Weakness? No Yes

Dislocations? No Yes

↳ If Yes, how many have you had? _____

To treat your symptoms have you had any:

Physiotherapy? No Yes

Injections? No Yes

↳ If Yes, how many have you had? _____

Surgery? No Yes

↳ If Yes, when? _____

Type/Name? _____

Other treatments? No Yes

↳ If Yes, what? _____



Tick the box next to the answer that best fits. Please only give one answer per question.

1 During the past 4 weeks...

How would you describe the worst pain you had from your shoulder?

None Mild Moderate Severe Unbearable

2 During the past 4 weeks...

Have you had any trouble dressing yourself because of your shoulder?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

3 During the past 4 weeks...

Have you had any trouble getting in and out of a car or using public transport because of your shoulder?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

4 During the past 4 weeks...

Have you had any trouble using a knife and fork at the same time?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

5 During the past 4 weeks...

Have you had any trouble doing the household shopping on your own (or could you)?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

6 During the past 4 weeks...

Have you had any trouble carrying a tray with a plate of food across the room (or could you)?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

7 During the past 4 weeks...

Have you had any trouble brushing or combing your hair with your sore arm (dominant or not)?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

8 During the past 4 weeks...

How would you describe the type of pain you most often had from your shoulder?

None Very Mild Mild Moderate Severe

9 During the past 4 weeks...

Have you had any trouble hanging up your clothes up in a wardrobe using the sore arm (or could you do it)?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

10 During the past 4 weeks...

Have you been able to wash and dry yourself under both arms?

No trouble at all A little bit of trouble Moderate trouble Extreme difficulty Impossible to do

11 During the past 4 weeks...

How much pain from your shoulder interfered with your usual work (including housework)?

Not at all A little bit Moderately Greatly Totally

12 During the past 4 weeks...

Have you been troubled by pain from your shoulder in bed at night?

No 1 or 2 nights Some nights Most nights Every night

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)

NOTE: 0 = unable to do and 3 = easy to do

LEFT Shoulder (we need both for comparison) 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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sleep on your side	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Wash your back or do your bra up	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Manage toileting	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Comb hair (or if bald/other handed, do that action)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Reach a high shelf	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Lift 5kgs or 10lbs above the shoulder	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Throw a ball overhand	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Do your usual work or activities	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Do your usual sport or hobby/leisure activity	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

↑ Unable Very difficult A bit difficult Easy to do

- 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 (eg Panadol, Nurofen, Aspirin etc?) Yes No
- Do you take narcotic medication (eg Panadeine, Nurofen Plus or stronger?) Yes No
- How many tablets would you take each day (on average) **just for your shoulder?** _____ tablets
- Does your shoulder feel unstable (i.e. as if it is going to dislocate)? Yes No
- If 0 = not at all and 10 = unstable, how unstable does your shoulder feel **today** out of 10? _____

Consent to Collect Patient Information – Privacy Act 2002

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 that we may properly assess, diagnose, treat and be proactive in your health care needs. **NB:** please refer to our practice *Privacy Policy* online at www.sydneyshoulder.com.au or ask for a copy.

We will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your care, including doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

ADDENDUM

I also understand that I seek the care of Dr Young for my medical management and that it is a policy of the practice that Dr Young does not undertake examinations and/or reports for the purpose of Medico-Legal matters or Third Party claims.

Signed (*digital signature not required*): _____ Today's Date: ____/____/____

Patient Name (*typed or printed*): _____ **Thank you for completing this form**



Please now save the form then attach to an email and send to youngadmin@sydneyshoulder.com.au

