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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:____

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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?* ______________________________

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The Oxford Shoulder Score

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 ☐

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The American Shoulder & Elbow Society Rating Scale

1 If 0 = no pain and 10 = the worst pain, how bad is your pain **today** out of 10? _____
2 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 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Sleep on your side	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Wash your back or do your bra up	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Manage toileting	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Comb hair (or if bald/other handed, do that 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 hobby/leisure activity	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
	Unable	Very difficult	A bit difficult	Easy to do	Unable	Very difficult	A bit difficult	Easy to do

3 Are you having pain in your shoulder? Yes ☐ No ☐
4 Do you have pain in your shoulder at night? Yes ☐ No ☐
5 Do you take pain medication (eg Panadol, Nurofen, Aspirin etc?) Yes ☐ No ☐
6 Do you take narcotic medication (eg Panadeine, Nurofen Plus or stronger?) Yes ☐ No ☐
7 How many tablets would you take each day (on average) **just for your shoulder**? ____ tablets
8 Does your shoulder feel unstable (i.e. as if it is going to dislocate)? Yes ☐ No ☐
9 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:

1. Administrative purposes in running our medical practice
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
3. 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

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