Greg Sterling ORTHOPAEDICS

DR GREG STERLING
Surgery of the Foot and Ankle

FOOT AND ANKLE FORM

PATIENT REGISTRATION FORM

Title: Dr/Mr/Mast/Mrs/Miss/Ms Other: _____ (please circle)

Patient Surname: _____

Given Names: (as appears on Medicare card) _____

Preferred Name: _____

Sex: Male/Female (please circle)

Patient's Street Address: _____

Suburb: _____ Post Code: _____

Patient's Mailing Address (if different from above): _____

Suburb: _____ Post Code: _____

Date of Birth: _____

Contact Phone Numbers:
Home: ( ) _____ Work: ( ) _____

Mobile: _____

Contact email address: _____

Please sign if you consent to receiving appointment reminders via email: _____

Medicare: Number: _____Ref: _____ Expiry Date: _____

DVA Number: _____ Gold or White Card (please circle) Expiry: _____

HCC/Pension Number: _____ Exp: ____ / ____/ _____

Information and appointments online see www.bkss.com.au

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WORKCOVER/ INSURANCE DETAILS:

Claim Reference: _____

Insurance Provider: _____

Location: _____

Case Manager: _____

Contact Phone: ( ) _____

HEALTH CARE DETAILS:

Health Fund: Name: _____

Membership Number: _____

Level/Type Of Cover: _____

Next of Kin: Name: _____

Relationship: _____

Phone: ( ) _____Mobile: _____

Parent/Guardian Details (if under 18 years old):

Name: _____

Address: _____

Relationship to Patient: _____

REFERRAL DETAILS:

General Practitioner – if not the doctor referring: _____

General Practitioner Address: _____

_____

Physiotherapist/ Other
(Copies of Letters to be sent to) _____

_____

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CONSENT FORM

The Privacy Act requires us to obtain your permission to collect some information about you.

i) We will take your personal details.
ii) We may require you to fill out some forms about your condition.

The primary reason is to provide you with quality health care, to be able to properly assess and diagnose you. We also use the information for

i) Communication with others involved in your care.
This includes your referring doctor who will receive a letter outlining the outcome of your consultation.
It also may include specialists and therapists involved in your care.
ii) Administrative purposes.
This includes maintenance of records and billing. In the event of any outstanding accounts, this information may also be forwarded to a collection agency.
iii) Research and education.
Your doctor is involved in teaching, research and quality assurance. He may take photographs of your x-rays or operation and use them for teaching. Your name would NOT be disclosed. He collects information about the number, type and outcome of all operations done and may use this for research or quality assurance. Again you would remain ANONYMOUS.

You are not required to provide this information or give permission for it to be used as described above. However your failure to do so may compromise the treatment we are able to give you.

I have read and understood the above. I agree to provide the necessary information and for it to be used for the purposes outlined above.

Signature of patient / parent/ guardian……..

Name……..

Date……..

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This information will help your doctor to understand your problem. Please complete the form as completely as possible. If you have any questions, do not hesitate to ask your doctor.

Name:_____

Today's Date:_____**Age:**_____

Occupation: _____

Please tick one: ☐ **Right foot/ankle** ☐ **Left Foot/Ankle** ☐ **Both Feet/Ankles**
If both, which is more painful (circle)? Right Left

Please describe your problem: _____

When did your symptoms begin? _____

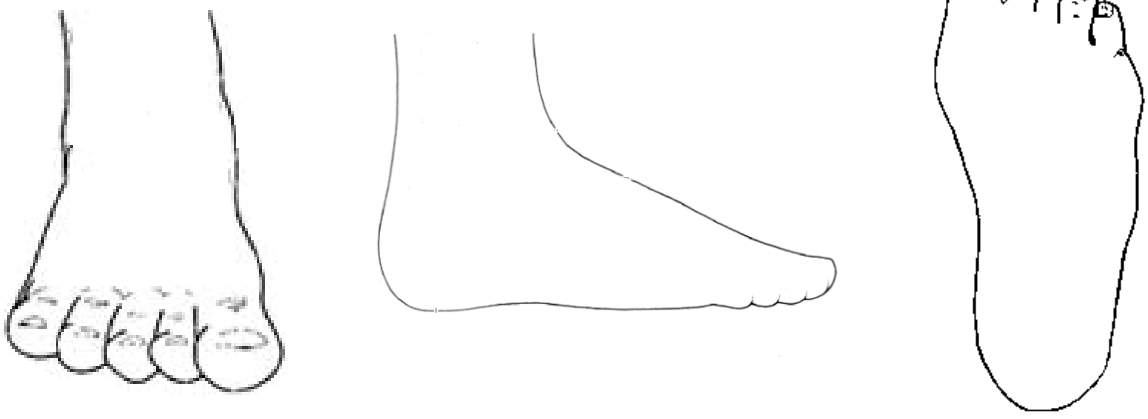
How did they begin? _____

Are they: ☐ **Improving?** ☐ **Worsening?** ☐ **Staying the same?**

Please describe your symptoms:

Level of discomfort (circle): **Minimal 0 1 2 3 4 5 6 7 8 9 10 Severe**

Where does it hurt? **(Shade in where the pain is on the diagram)**



Other sites of pain? _____

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How would you describe the pain? (Tick all that apply)

- ☐ Sharp
- ☐ Intermittent
- ☐ Burning
- ☐ Electric Shocks
- ☐ Other_____
- ☐ Dull
- ☐ Constant
- ☐ Tingling
- ☐ Throbbing

Do you have any other symptoms? (Tick all that apply)

- ☐ Stiffness Where? _____
- ☐ Numbness Where? _____
- ☐ Swelling Where? _____
- ☐ Locking/catching Where? _____
- ☐ Weakness Where? _____
- ☐ Instability When? _____

What makes your symptoms worse? (Tick all that apply)

- ☐ Running
- ☐ After activities
- ☐ Daytime
- ☐ Stairs
- ☐ Sports
- ☐ During activities
- ☐ Night
- ☐ Other _____

What makes your symptoms better? (Tick all that apply)

- ☐ Rest
- ☐ Heat
- ☐ Brace/Splint
- ☐ Exercise
- ☐ Therapy
- ☐ Cold
- ☐ Walking aid
- ☐ Other _____

Do you have pains in any other joints? ☐ No ☐ Yes **Which ones?** _____

What investigations have you had? (Tick all that apply)

- ☐ Blood tests
- ☐ Ultrasound
- ☐ X-rays
- ☐ CT scan
- ☐ MRI scan
- ☐ Bone scan

What treatment have you tried? (Tick all that apply)

- ☐ None
- ☐ Physiotherapy
- ☐ Cast
- ☐ Brace
- ☐ Surgery; what? _____
- ☐ Other _____
- ☐ Steroid Injections
- ☐ Walker Boot
- ☐ Shoe Insert

Do you suffer from one of the following? (Tick all that apply)

- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Psoriasis
- ☐ Enteropathic Arthritis

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Is there a family history of any arthritis or psoriasis?
☐ No ☐ Yes Which? _____

Other past medical history: (e.g. Diabetes, Asthma, Blood Clots)

_____
_____
_____
_____
_____

Medications – please list:
For this condition:

_____

_____

_____
Other medications
_____

_____

_____

_____

_____

Do you smoke? ☐ No ☐ Yes – How many per day?_____

Future work and recreational/sporting plans:

_____
_____
_____
_____
_____
_____

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Foot and Ankle Survey

INSTRUCTIONS:
This survey asks for your view about your foot/ankle. This information will help us keep track of how you feel about your foot/ankle and how well you are able to do your usual activities. Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Pain

Rate your level of pain: (tick one)

- ☐ **None**
- ☐ **Mild, occasional**
- ☐ **Moderate, daily**
- ☐ **Severe, almost always present**

Function

Rate your activity limitations and support requirement: (tick one)

- ☐ **No limitations, no support**
- ☐ **No limitation of daily activities, limitation of recreational activities, no support**
- ☐ **Limited daily and recreational activities, cane**
- ☐ **Severe limitation of daily and recreational activities, walker, crutches, wheelchair, brace**

Rate your maximum walking distance in blocks: (tick one)

- ☐ **Greater than 6 blocks**
- ☐ **4-6 blocks**
- ☐ **1-3 blocks**
- ☐ **Less than 1 block**

When walking on surfaces, you have: (tick one)

- ☐ **No difficulty on any surface**
- ☐ **Some difficulty on uneven terrain, stairs, inclines, ladders**
- ☐ **Severe difficulty on uneven terrain, stairs, inclines, ladders**

The footwear you require is: (tick one)

- ☐ **Fashionable, conventional shoes, no insert required**
- ☐ **Comfort footwear, shoe insert**
- ☐ **Modified shoes or brace**