Greg Sterling ORTHOPAEDICS

DR GREG STERLING
Surgery of the Knee

KNEE 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: ____ / ____/ _____

WORKCOVER/ INSURANCE DETAILS:

Claim Reference: _____

Insurance Provider: _____

Location: _____

Case Manager: _____

Contact Phone: ( ) _____

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

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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)
_____

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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KNEE QUESTIONNAIRE

Name: **Date:**
Age: **Birth Date:**
Is this Workcover: Y ☐ N ☐ **What is your job description:**

What is the problem with your Knee?

Is the current problem a result of :

Car Accident	☐	If Other please specify:
Work injury	☐	
Sports Injury	☐	
Other	☐	

HISTORY

Which knee is the problem? R ☐ L ☐ Both ☐

When did the problem start?

Have you had previous problems with your knee?

What problems are you experiencing? Please tick all that apply

Pain	☐	
Stiffness	☐	
Catching/locking	☐	
Weakness	☐	
Swelling	☐	
Limited Motion	☐	
Instability / dislocation	☐	
Grinding / popping	☐	
Clicking	☐	

What makes the problem better?

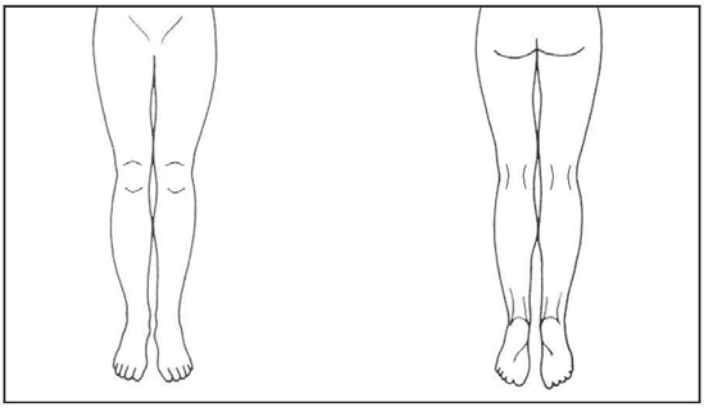
What makes the problem worse?

PAIN

Quality of pain:

Throbbing	☐	
Sharp	☐	
Dull	☐	
Aching	☐	
Stabbing	☐	
Burning	☐	

Location of pain: Please mark location on diagram.



How severe is your pain? Please mark on the score below

NO PAIN 0_1_2_3_4_5_6_7_8_9_ 10 SEVERE PAIN

Frequency of pain:		
Rarely	☐	
Occasionally	☐	
Frequently	☐	
Constantly	☐	
When does the pain occur?		
Morning	☐	
Day	☐	
Evening	☐	
Night	☐	
Interrupts sleep, if so how many times?	☐	
Weather change	☐	
When is the pain made worse?		
Resting	☐	
At work	☐	
Driving	☐	
Other	☐	
When is the pain relieved?		
Nothing	☐	
Rest	☐	
Activity	☐	
Medication	☐	
Injection	☐	
Physiotherapy	☐	
Ice	☐	
Heat	☐	

ACTIVITIES

Do you have difficulty with the following activities:

Activity	Right Leg	Left Leg
Kneeling	Y☐ N☐	Y☐ N☐
Squatting	Y☐ N☐	Y☐ N☐
Ascending stairs	Y☐ N☐	Y☐ N☐
Descending stairs	Y☐ N☐	Y☐ N☐

PRIOR TREATMENT FOR THIS PROBLEM

Have you seen a specialist for this problem Y ☐ N ☐ if yes, whom:

What was the diagnosis?

What was their treatment?

Type of treatment	Type	How often	Period of time	Help	Hurt	No effect
Analgesics				☐	☐	☐
Anti-inflammatories				☐	☐	☐
Cortisone injections				☐	☐	☐
Rest				☐	☐	☐
Chiropractic				☐	☐	☐
Massage therapy				☐	☐	☐
Acupuncture				☐	☐	☐
Bracing of the knee				☐	☐	☐

Physiotherapy treatment? Y ☐ N☐ if yes, please detail below.

Day / Month / Year	Physiotherapist	Type of Physio	Results

Previous knee surgery? Y ☐ N ☐ if yes, please detail below.

Month/Day/Year	Surgeon	Type of surgery	Results

X – RAYS / SCANS

X – rays / ultrasound: Y ☐ N ☐ If yes, please complete below

Day/ Month / Year

Previous MRI /CT scan : Y ☐ N ☐ If yes, please complete below

Month / Day / Year	Location	Type of scan	Results

MEDICAL HISTORY		
Please circle		
Do you suffer from hip problems?	N ☐	Y ☐
Do you have any back problems?	N ☐	Y ☐
Do / did you have any heart problems?	N ☐	Y ☐
Do / did you have ulcers / gastritis?	N ☐	Y ☐
Do / did you have diabetes?	N ☐	Y ☐
Do / did you have liver problems / hepatitis?	N ☐	Y ☐
Do / did you have kidney disease?	N ☐	Y ☐
Do / did you have cancer?	N ☐	Y ☐
Do /did you have blood clots?	N ☐	Y ☐
Do /did you smoke cigarettes? (if yes, how many)	N ☐	Y ☐
Do / did you drink alcohol? (if yes, how many units per week)	N ☐	Y ☐
Do you suffer from any allergies?	N ☐	Y ☐

Please use the space below to explain any of the above