Dr Mark Shillington
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ORTHOPAEDIC SURGEON

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Consulting Rooms in Ipswich and Brookwater

Please take the time to read through these forms thoroughly and when all the required information has been supplied, hand back to the receptionist to allow her to create your patient chart.

Do not hesitate to ask Dr Shillington's receptionist if you have any queries about these forms.

PART A: PATIENT DETAILS

TITLE: (PLEASE CIRCLE) MR MRS MS MISS MASTER OTHER

SURNAME: _____

GIVEN NAMES: _____

ADDRESS: _____

TELEPHONE NO: (H) _____ **(W)** _____ **(M)** _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____

MEDICARE CARD NUMBER: _____ **EXPIRY DATE:** _____/_____ **POSITION ON CARD:** ___

PRIVATE HEALTH FUND NAME: _____ **NUMBER:** _____

DEPARTMENT VETERANS AFFAIRS CARD NUMBER: _____ **TYPE: (PLEASE CIRCLE) WHITE GOLD**

USUAL GP: (IF DIFFERENT FROM REFERRAL) _____

NEXT OF KIN NAME: _____ **TELEPHONE NO:** _____

If this is a workers' compensation claim, please fill in the details in the section below:

WORKERS' COMPENSATION ORGANISATION: _____

WORKERS' COMPENSATION CLAIM NUMBER: _____

WORKERS' COMPENSATION CONTACT PERSON: _____ **PHONE:** _____

If parent or guardian of above patient, please complete the section below:

TITLE: _____ **SURNAME:** _____ **GIVEN NAMES:** _____

DOB: _____ **POSITION ON MEDICARE CARD:** _____

NAME: _____

I consent to the above information being used for some or all of the following purposes by Dr Shillington and/or his secretary:

- Creating an account for consultations, operations, reports.
- Booking operations and/or treatments.
- Referrals to other doctors, for pathology, radiology, etc.

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Signature (Patient or Guardian) Date

PART B: PATIENT HISTORY

ALLERGIES

Do you have any allergies to medications, food, sticking plaster, latex/rubber (e.g. balloons or gloves) or anything else? If so, please list allergies and reactions below.

Allergy	Reaction

MEDICATIONS

Have you recently taken:	Please Tick Yes	No
Blood Thinning Medication		
Warfarin		
Aspirin		
Steroids or Cortisone		
Please List All Other Current Medications:		

NAME: _____

LIFESTYLE

	Please Tick	
	Yes	No
Are you a smoker?		
If so, how many cigarettes do you smoke per day?		
Do you drink alcohol?		
If so, what is your daily intake?		
Have you ever suffered from a blood clot in the lung or leg?		
If so, when?		

DIABETES

DO YOU HAVE DIABETES: _____ **YES** ◯ **NO** ◯____

IF YES:

WHAT MEDICATIONS:

_____

_____

_____

_____

DATE OF LAST DIABETES BLOOD TEST (HbA1c):_____

BODY WEIGHT: _____

HEIGHT: _____