act PODIATRY
Advanced Foot & Ankle Centre

New Patient Registration Form

Title _____ Name _____
Address _____
Suburb _____ Postcode _____ Date of birth _____
Best Contact Numbers _____ Occupation _____
Email address _____
Body weight (kg) _____ Height (feet/inches or cm) _____ Shoe size _____
What is your main concern/s today? _____
Where is your pain located? _____
How long have you had this problem? _____
What makes your pain better and/or worse? _____
On a scale of 1-10 how severe is your pain? (circle)
No pain 1 2 3 4 5 6 7 8 9 10 Severe pain
Relevant family medical history (ie - diabetes) _____
_____
Exercise: Activities and frequency (e.g. walking daily, gym classes twice a week, yoga every day etc).
_____
Are you currently, or have you ever been a smoker? Yes / No
If yes, number per day? _____ What year did you give up? _____

Medications (including supplements) [eg. Lipitor 40mg 1 tab at night]	**Allergies** (including dietary restrictions) [eg. Penicillin allergy, gluten intolerance etc]	**Issues** (previous surgery/other health issues) [Please include year of surgery/condition]

Next of kin / contact person in an emergency
Contact person _____ Relationship _____ Contact _____
Your GP (doctor) name _____ Clinical address _____
Private health cover? (if none, leave blank)
Insurance Co. _____ Membership No. _____ Line No. _____
Medicare No. _____ _____ _____ _____
(MEDICARE No.) (LINE No.) (EXPIRY MONTH/YEAR)

Are you an EPC patient (Enhanced Primary Care) Yes / No
DVA: Are you a DVA patient? (Department of Veteran Affairs) Yes / No If yes, Gold Card / White Card
Patient No: _____ Card No: _____
Work Cover: Are you a Workcover patient? (claiming workers compensation) Yes / No
Your employer: _____ Insurance Co: _____ Claim No: _____
Date of injury: _____ / _____ / _____ Case manager: _____ Contact ph: _____

ABN 50 090 396 875

ACT PODIATRY Suite 8 (Gnd floor) Cnr Reed St (North) & Scollay St GREENWAY ACT 2900
Phone 02 6287 4889 or 02 6296 4994 Fax 02 6287 5139 admin@actpodiatry.com.au

Acute Health Issues
Recent event or currently affected: Please tick all that apply ☐ NONE

- ☐ Loss of appetite
- ☐ Blurred vision
- ☐ Ringing ears
- ☐ Pain with swallowing
- ☐ Swelling of feet
- ☐ Incontinence
- ☐ Balance difficulty
- ☐ Co-ordination difficulty
- ☐ Headaches
- ☐ Muscle weakness
- ☐ Joint stiffness / swelling
- ☐ Nausea
- ☐ Fever
- ☐ Constipation
- ☐ Weight loss
- ☐ Fatigue
- ☐ Nose bleeds
- ☐ Cold hands or feet
- ☐ Fainting
- ☐ Frequent urination
- ☐ Memory loss
- ☐ Dizziness
- ☐ Tremors
- ☐ Joint pain
- ☐ Diarrhoea
- ☐ Double vision
- ☐ Vomiting

Chronic Health Issues
Please tick all that apply ☐ NONE

- ☐ Acid Reflux
- ☐ Alcoholism
- ☐ Anaemia
- ☐ Anaesthesia difficulties
- ☐ Anxiety
- ☐ Arthritis
  Type:
- ☐ Arrythmia
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Blood clots / DVT
- ☐ Bowel disorders
- ☐ Bronchitis
- ☐ Cancer
  Type:
- ☐ Chest pains
- ☐ Chronic pains
- ☐ Chronic back pain
- ☐ Circulation disorders
- ☐ Colour changes of skin
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Hearing deficit
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatits
  Type:
- ☐ Hiatus hernia
- ☐ High blood pressure
- ☐ History of alcohol dependency
- ☐ History of drug dependency
- ☐ HIV/AIDS
- ☐ Implants
  Type:
- ☐ Irritable bowel syndrome
- ☐ Keloids / scar formations
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leg pain / cramps
- ☐ Lung disease
- ☐ Migraine headaches
- ☐ Mitral valve prolapse
- ☐ Murmur
- ☐ Muscle disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Prostate disease
- ☐ Psoriasis
- ☐ Pulmonary embolism
- ☐ PVD
- ☐ Reflex
- ☐ RSD / CRPS
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sickle cell anaemia
- ☐ Sleep apnoea
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
  Type:
- ☐ Varicose veins
- ☐ Vision problems
- ☐ Other

At ACT Podiatry we respect your privacy. All information collected, is stored securely and accessed only by our staff. In order to provide the highest standard of care, there are times when we may communicate with your other health care providers.

I have read the privacy statement and I consent to the collection and dissemination of information as described. I understand the provision of my medical history is necessary to provide me with effective, safe and efficient podiatric management. I have answered all questions to the best of my knowledge. I agree to notify my podiatrist / podiatric surgeon of any change in my health.

Signature _____ Date _____

ABN 50 090 396 875

ACT PODIATRY Suite 8 (Gnd floor) Cnr Reed St (North) & Scollay St GREENWAY ACT 2900
Phone 02 6287 4889 or 02 6296 4994 Fax 02 6287 5139 admin@actpodiatry.com.au

OFFICE USE ONLY: (surgical patients only) **DATE ENTERED: / /**

Does the patient need surgery: Y / N / Maybe Theatre / Room L.A / G.A / Sedation

Ankle arthrodesis	49712	F858	R: L:	Ankle arthroplasty	50127	F746	R: L:
Cheilectomy	48400	F715	R: L:	Excision of benign lesion	31210	F445	R: L:
Digital arthrodesis	49851	F856	R: L:	Excision of soft tissue	30107	F704	R: L:
Digital arthroplasty	49848	F739	R: L:	Excision of tarsal coalition	50333	F791	R: L:
Hallux limitus (CIA)	48400	F715, F725, F689	R: L:	Ligament/capsule repair	50106	F692	R: L:
HAV (bunion)	49833	F782, F793, F687, F689	R: L:	Metatarsalphalangeal arthrodesis	49845	F852	R: L:
Metatarsal osteotomy	48403	F782	R: L:	Plantar fasciectomy	49809	F699	R: L:
Neurectomy	49866	F702	R: L:	Plantar fasciotomy	49809	F698	R: L:
Partial nail avulsion	49716	F576	R: L:	Tailors bunion	48403	F784	R: L:
Phalangeal osteotomy	48400	F725	R: L:	Tarsal arthrodesis	49815	F857	R: L:
Tarsal osteotomy	48409	F787	R: L:	Tarsal arthroplasty	50127	F744	R: L:
Tenotomy	49809	F687	R: L:	Tarsal ostectomy	48406	F721	R: L:
Tenoplasty	49809	F55	R: L:	Weil osteotomy (lesser metatarsal)	48403	F784	R: L:

ACT PODIATRY Suite 8 (Gnd floor) Cnr Reed St (North) & Scollay St GREENWAY ACT 2900
Phone 02 6287 4889 or 02 6296 4994 Fax 02 6287 5139 admin@actpodiatry.com.au