Dr David Dilley

**to maintain your medical records, it is necessary to have the following information which *will be treated confidentially*.**

 Title:…….. Family Name:………………………..... Given Name:…………………………………………

Residential Address:……………………………………………………………………………………………

Postal Address:………………………………………………………………………………………….

E-Mail:……….………………….………………@…………..…………………………………

Phone: Mobile……………………..….Home………………………...Work……..………...….

Birth Date:……………………………

Medicare No\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Your Reference No:\_\_\_\_ Valid To:\_\_\_/20\_\_\_

Vet Affairs No…………………………

Health Fund Name:…………………………….. Membership Number:………………………...

Occupation:……………………………………….

Next of Kin:……………………………………PHONE:…………………………………….

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Dear Patient,
 A*ll care is given to *you personally.* Therefore, the final responsibility and liability for *all fees* is yours whether or not you think a third party (eg Medicare, Health Fund, Workcover etc.) may pay all or some of your account.**

Is this covered by Workers’ Comp? YES/NO

INSURANCE Co:……………………………….……….Claim No:………..…………...………….

ADDRESS………………………………………………………………………..……………….…

NAME OF CASE MANAGER………………………………………………………………………

Case Manager Email…………………………………………@.........................................................

PHONE NO………………………………………FAX NO…………………………………………

**Date of Injury:……………………….. Employer Name…………………………………………..**

**Employer Address:…………………………………………………………………………………..**

**Employer Phone:……………………………………..Fax:…………………………………………**

# Patient History

Date of injury or onset of problem (approx.):…………………………………………..

Which is your dominant hand? *(please tick)*

 Left Right Both (ambidextrous)

Which hand has the problem/injury?

 Left Right Both

Occupation:…………………………………………Time in present job……………………...

Describe your duties…………………………………………………………………………….

…………………………………………………………………………………………………..

Hobbies………………………………………………………………………………………….

Previous Operations…………………………………………………………………………….

Medications……………………………………………………………………………………..

Allergies………………………………………………………………………………………..

Smoker? No Yes………/day Alcohol? No Yes…….drinks/day

Do you or any of your relatives suffer from the following?

|  |  |  |
| --- | --- | --- |
|  | **Me** | **Family *(relationship)*** |
| Rheumatoid Arthritis |  | …………………… |
| Other Arthritis |  | …………………… |
| Diabetes |  | …………………… |
| High/Low Blood Pressure |  | …………………… |
| Angina/Heart Problems |  | …………………… |
| Asthma/Lung Problems |  | …………………… |
| Kidney Trouble |  | …………………… |
| Other Health Issues……………………….. |  | …………………… |

# The Present Problem

What is troubling you?

|  |  |  |  |
| --- | --- | --- | --- |
|  Pain |  Stiffness |  Numbness |  Other………….. |

How did it start?...........................................................................................................................

…………………………………………………………………………………………………..

Does anything set it off?...............................................................................................................

…………………………………………………………………………………………………..

…………………………………………………………………………………………………..

What makes it better/worse?........................................................................................................

…………………………………………………………………………………………………..

Do you need to take tablets for pain?

|  |  |
| --- | --- |
|  No |  Yes |
|  | Which tablets?..........................................................How many/day?……….. |

Does the pain or discomfort stop you getting to sleep or wake you after falling asleep?

………………………………………………………………………………………………......

…………………………………………………………………………………………………..

…………………………………………………………………………………………………..

Does this problem stop you from doing something you want to do? What?..............................

…………………………………………………………………………………………………..

…………………………………………………………………………………………………..

With time, is the problem:

|  |  |  |
| --- | --- | --- |
|  staying the same? |  getting worse? |  getting better? |

Any other relevant information?..................................................................................................

…………………………………………………………………………………………………..

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