Dr Katherine Gordiev
Orthopaedic Surgeon
MBBS (Hons 1) FRACS FAOrthA

PATIENT INFORMATION

Mr / Mrs / Ms / Miss / Master / Dr / Other …… Gender ……..

Given Names …… Surname ……

Known As …… Date of Birth …….. Age ……

Phone: (H) ……..…. (W) ……..…….. (M) ……..……..

Email .....

Street Address ……..

…… Post Code …….

Occupation ……..

Emergency Contact ……..…….. Relationship ……..…… (M) ……

General Practitioner ……...

Doctor's Address ……....

Referring Doctor (if different) ……..……

Physiotherapist ……..

Physiotherapist's Address ……..

Private Health Fund ……..…… Member No ……..……

Medicare No ☐☐☐☐ ☐☐☐☐☐ ☐ Position on Card ☐ Expiry Date……..

If Patient is Under 15 Years Old (parent details)

Parent Name …… Date of Birth …… Medicare No ……

Workers Compensation Yes ☐ **No** ☐

Date of Onset:……...

Employer:……

Insurer:……..

Rehabilitation: Company & Case Manager ……...

Contact……...

ADF

Military EP ID No …… Rank ……PMKeys No……..

Veterans' Affairs No …… Expiry …… White / Gold Card……....

Suite 7, Level 2, National Capital Private Hospital, Gilmore Crescent, Garran, ACT
Phone : 6260 5249 | Fax : 6282 8313 | Email: reception@katherinegordiev.com.au

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MEDICAL HISTORY

Name …… Height ……..…cm Weight ……..……kg

Date of injury / when did the symptoms first occur ……..

What Sports or Physical Activities Do You Participate In ……..

……

Do you suffer from any of the following medical illnesses?

High Blood Pressure	Yes/No	Heart Disease	Yes/No	Heart Attack	Yes/No
Angina/Chest Pain	Yes/No	Heart Murmur	Yes/No	Stroke/T	Yes/No
Circulation Problems	Yes/No	Bleeding Disorders Yes/No	Yes/ No	Leg Cramps	Yes/No
Asthma/Airways Disease	Yes/No	Bronchitis	Yes/No	Diabetes	Yes/No
Thyroid Disease	Yes/No	Renal/Kidney Problems	Yes/No	Epilepsy	Yes/No
Stomach Ulcers/Reflux	Yes/No	Liver Disease/Jaundice	Yes/No	Hepatitis B or C	Yes/No
Mental Health Issues	Yes/No	Rheumatic Fever	Yes/No	Sleep Apnoea	Yes/No
Blood Clots Leg/Lung	Yes/No	Family History of Clots	Yes/No		
HIV/AIDS	Yes/No	Contact with HIV/AIDS or Hepatitis B			Yes/No

Cancer……..……..…… Other ……..…

Have you ever had a blood transfusion? Yes/No If yes, when ……..…..……

Any problems/reactions ……..……..

Do you take any of the following :

Aspirin	Yes/No		Oral Contraceptive Pill / Implant		Yes/No
Hormone Replacement	Yes/No				
Anti-arthritic Medication	Yes/No	Anti-coagulants	Yes/No		
Plavix	Yes/No	Xarelto	Yes/No	Iscover	Yes/No
Warfarin	Yes/No	Heparin	Yes/No	Clexane	Yes/No
Xarelto	Yes/No	Eliquis	Yes/No		

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NAME : D.O.B : DATE :

Current Medications Including non-prescription :

…… ……

…… ……

…… ……

Current Allergies :

…… ……

…… ……

Past Operations :

…… ……

…… ……

Have you previously had any anaesthetic problems : Yes/No

Have you been told you have a difficult airway : Yes/No

Do you smoke : Yes/No If Yes, how regularly …….

Do you drink alcohol : Yes/No If Yes, drinks per week …….

Please provide any additional information you think is important for us to know:

……

……

……

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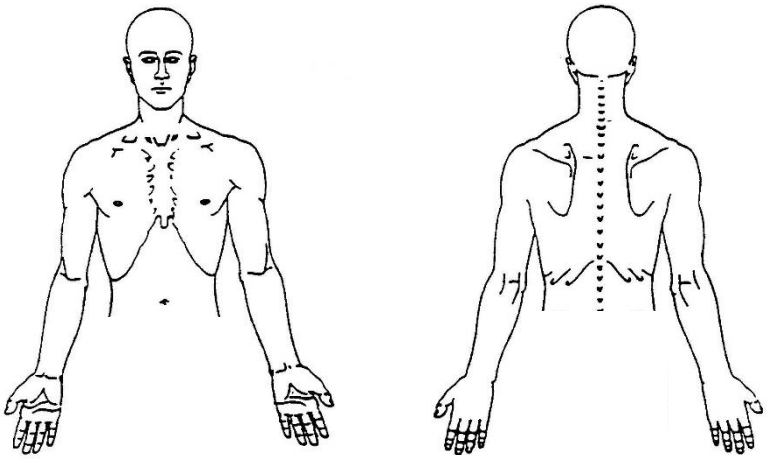
NAME : D.O.B : DATE :

On the diagram below, please mark the location of the pain:



Date of injury / when did the symptoms first occur ……..

Please circle the answer that best describes your symptoms.

Constant Score	Question	Patient to Complete	Dr Gordiev to complete
Pain	Please circle one	Severe Moderate Mild None	0 5 10 15
	Total		**15**
Activity Level	**Sleep Affected** Circle one	Yes No Sometimes	0 1 2
	Sports / Recreation Limitation Circle one	Unable Severely Sometimes Rarely Unlimited	0 1 2 3 4
	Work Limitation Circle one	Unable to work due to pain Severely Sometimes Rarely Not Limited	0 1 2 3 4
	To What Level Can You Use the Arm Circle one	Below waist height At waist height At chest height At neck level Up to top of head Above head height	0 2 4 6 8 10
	Total		**20**

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Your consultation is in the private rooms of a private clinic

- I understand that full payment for consultation and consumables is required at the time of the consultation. If difficulties with payment are anticipated, please discuss with Dr Gordiev's staff prior to the appointment.
- It is not the policy of this practice to bulk bill for services rendered
- In cases where unpaid accounts are referred to a Collection Agency, all legal costs and omission will be added to the amount due.
- Workers' Compensation/Third Party claims will need to be settled at the time of consultation if prior approval I not received in writing from the insurer.
- I give consent for medical information concerning myself, or my child, to be released to my insurer, employer, solicitor, my referring GP, and other health professionals involved in my care.
- I give consent to the above information and any other relevant medical information being scanned and stored in my electronic patient file.

NAME ……..

SIGNATURE ……

DATE ……

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