DR MICHAEL LUTZ
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PATIENT REGISTRATION FORM **WorkCover**

Title: _____First Names:_____Surname: _____

Preferred Name (known as):_____Date of Birth: _____

Residential Address: _____

_____Suburb:_____Postcode: _____

Postal Address: _____

Phone: Home: _____Work:_____Mobile:_____

Email Address:_____Occupation:_____

WORKCOVER/THIRD PARTY DETAILS

Employer: _____ Date of Injury:_____ /_____/_____

Insurance Provider:_____ Claim/Ref No:_____

Case Manager: _____Ph No: _____

Injury Sustained:_____ Location of Injury:_____

Cause:_____

GP DETAILS: _____

Clinic: _____ Suburb: _____

Physiotherapist _____

Clinic: _____ Suburb: _____

Podiatrist _____

Clinic: _____ Suburb: _____

NEXT OF KIN

Name:_____ Relationship:_____

Phone No: _____

PRIVACY

I, (print name) _____ consent to this practice collecting, holding, using and disclosing my personal information (including health information, clinical photographs and other sensitive information) for administration and billing purposes and to others involved in your care (i.e. treating doctors and specialists outside this practice).

Signature _____ Date _____ /_____/_____

Name: _____ DOB: _____

HEALTH QUESTIONNAIRE

Height: _____ Weight: _____

Do you realise that excess weight significantly increases your risk of complications? ○ Yes ○ No

Are you diabetic? ○ Type 1 ○ Type 2 ○ No

Are you a smoker? ○ Yes_____per day ○ Never ○ Ex-Smoker_____years/months

If Yes, are you aware that smoking has serious adverse effect on skin and bone healing? ○ Yes ○ No

Are you on any of the following drugs?

Warfarin	○ Yes	○ No	Aspirin	○ Yes	○ No	Iscover	○ Yes	○ No
Clopigogrel	○ Yes	○ No	Insulin	○ Yes	○ No	Methotrexate	○ Yes	○ No
Prednisone	○ Yes	○ No	Xarelto	○ Yes	○ No	Other	○ Yes	○ No

Please list: _____

Do you have any allergies? ○No ○Latex ○ Penicillins ○ Sticking Plasters ○ Other

If "Other", please list: _____

Have you had any problems with a previous anaesthetic? ○ Yes ○ No

If so, please describe: _____

_____

Have you any of the following in the last 12 months?

Acute Myocardial Infarction (Heart attack)? ○ Yes ○ No

Had a Stent or a Pace Maker inserted? ○ Yes ○ No

Have you ever had a Deep Vein Thrombosis/Pulmonary Embolism? ○ Yes ○ No

Do you live alone? ○ Yes ○ No

If No, with? ○ Husband ○ Wife ○ Partner ○ Parents ○ Friend

If Yes, do you have someone close to you that can help you recuperate? ○ Yes ○ No

Do you have stairs at home? ○ Yes ○ No

At work are you mainly ○ Seated ○ Standing ○ Walking ○ 50/50

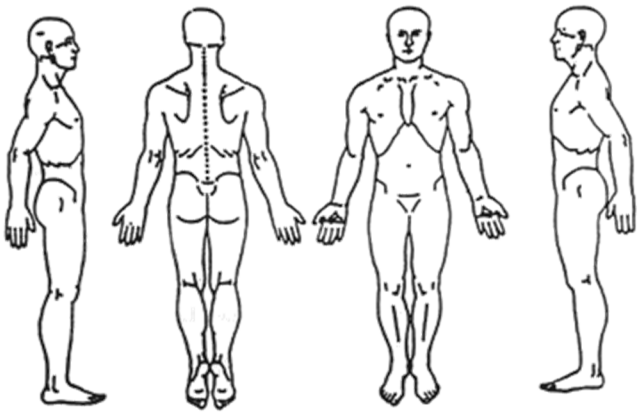
Can you modify your work for a time after surgery? ○ Yes ○ No

Name: _____ DOB: _____

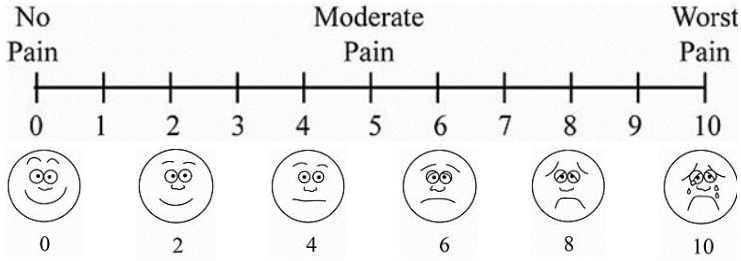
Area of problem: ○ Toe ○ Foot ○ Ankle

○ Achilles ○ Heel ○ Bunions

Side: ○ Left ○ Right ○ Both



On the following diagram, please indicate (by shading or circling) <u>where</u> you feel pain, and please write the number which describes your pain (out of 10) with reference to the scale below. (You can have more than one area of pain)



Duration of problem: ○_____Weeks ○ _____ Months ○ _____ Years

Please describe onset: _____

_____

_____

_____

_____

Pain occurrence: ○ Resting ○ Walking ○ Running ○ Morning ○ Night

Exacerbated by: ○ Stairs ○ Sport ○ Shoes ○ Uneven Ground

Improved by: ○ Rest ○ Orthotics ○Boot ○ Strapping ○ Anti-Inflammatories

○ TENS Machine ○ Other _____

Pain Level: ○ Nil ○ Moderate ○ Mild ○ Intermittent ○ Severe

Activity Level: ○ Normal ○Quite limited ○ Reduced walking/running

Previous Treatment: ○ Orthotics (soft/hard) ○ Physiotherapy ○ Boot ○ Strapping

○ Cortisone Injection ○ Anti-Inflammatories ○ Surgery ○ TENS Machine

○ Other _____