Mr Peter Manuel M.Sc. B.Sc. F.A.C.P.S.
PODIATRIC FOOT & ANKLE SURGEON

Confidential Patient Information Form

Personal Information

Title			
Surname			
First name			
Middle name			
Preferred name			
Date of Birth			
Residential address			
Postal address (if different)			
Phone number:			
Preferred Method of Contact (circle one)	Phone	Email	SMS
Email address			
Usual Doctor			
Medicare Number		**Ref No**	
Medicare Expiry			
Pension/HCC Number			
Pension/HCC Expiry			
Pension Card Type (circle one)	Pensioner Concession Card Health Care Card Commonwealth Seniors Health Card		
DVA Card Number			
DVA Card Colour (circle one)	Gold	White	
Health Ins. Fund Name			
Parent /Guardian Name (if under 18years)			
Parent/Guardian Phone Contact (if different)			

Would you like to have appointment reminders sent via SMS? (circle one)

Yes No

To assist with health initiatives are you Aboriginal or Torres Strait Islander? (circle one)

Aboriginal Torres Strait Islander No

Your health history

Current Medications (include over the counter medications, vitamins and minerals)

Operation/s history	
Details	Date
Details	Date
Details	Date
Details	Date
Details	Date

Allergies	**YES**	**NO**
Drugs		
Food		
Adhesive plaster		
Latex		
Other; please specify:		

Do you have any of the following:	**YES**	**NO**
High Blood Pressure		
Blood clot/s in leg/s or lungs		
Hepatitis / Jaundice		
Hay fever / Eczema		
Heart Problems		
Asthma / Bronchitis / Emphysema		
TB		
Anemia / other blood disorders		
Rheumatic fever		
Kidney disease		
Diabetes		
Epilepsy or fits		
Tropical diseases		
Any other medical diseases		
Normal Childhood diseases		

Viral disease		

Your health history (continued)

Do you have any of the following: (continued)	**YES**	**NO**
Skin problems		
Anticoagulant treatment (blood thinning tablets)		
Blood transfusion		
Persistent cough		
Pain in chest		
Females – Are you pregnant		
Do you smoke		
Do you drink alcohol		

Is there any other information that you believe we should know that may affect / or have an influence on the medical treatment / advice you will be provided with?

I confirm there is no other information that I am aware of that would influence the treatment / advice to be provided.
The history I have given is complete and accurate.

Signature _____

How did you hear about Ankle & Foot Health Group

Friends / Family	☐	Yellow Pages Online	☐	Internet	☐
Newspaper Ad/Article	☐	Yellow Pages Book	☐	Driving past	☐
Health practitioner referral	☐	White Pages	☐	Doctors referral	☐
Other, please specify	☐				