



Patient Information

PATIENT LABEL HERE

Family Name			
Given Names			
Title	<input type="checkbox"/> Dr <input type="checkbox"/> Miss <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other _____		
Date of Birth		<input type="checkbox"/> Female	<input type="checkbox"/> Male
Employment Status	<input type="checkbox"/> Student <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Pensioner <input type="checkbox"/> Other		
Do you identify as?	<input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> Both Aboriginal & TSI <input type="checkbox"/> Neither		
Street Address			
Suburb		Post Code	
Home Telephone Number		Mobile Number	
Email			
Transport	<input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Uber / Taxi <input type="checkbox"/> Ambulance <input type="checkbox"/> Other		
Language		Interpreter Required? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Medicare Number		Reference	Expiry
Funding (please select)	Third Party	Self-Funded	Worker's Comp Other
Private Health Fund Name		Hospital Cover? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Member Number			
Source of Referral	<input type="checkbox"/> GP <input type="checkbox"/> Specialist <input type="checkbox"/> Outpatient <input type="checkbox"/> Hospital ED <input type="checkbox"/> Other		
GP's Name & Practice Name			
GP's Address			
GP's Suburb		Post Code	
How did you hear about us?			

1. Are you being treated for any medical condition at the present?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please provide details.		
2. Have you been treated for any medical condition in the past year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please provide details.		
3. When was your last medical check-up?		
4. Has there been any change in your general health in the past year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please provide details.		
5. Do you have any allergies?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please provide details:		
Medications	_____	
Latex / rubber products	_____	
Other (ie: hay fever, foods)	_____	
6. Do you carry an Epi-pen?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Have you ever had a peculiar or adverse reaction to any medication including injections?		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Are you currently taking any medications?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please provide details:		



9. Do you have, or have you ever had, any of the following? Please tick the ones that apply.

Angina (chest pain)		Arthritis		Artificial joints / prostheses	
Asthma		Bleeding Disorder / Bruising		Cancer	
Diabetes		Drug / Alcohol Dependency		Heart Attack	
Heart Disease		Heart Murmur		Heart Transplant	
Heart Valve Replacement		Hepatitis		High Blood Pressure	
Jaundice		Kidney Disease		Liver Disease	
Lung Disease		Osteoporosis		Pacemaker	
Respiratory Disease		Rheumatic Fever		Seizures / Epilepsy	
Shortness of Breath		Steroid Therapy		Stomach Ulcers	
Stroke / TIA's		Thyroid Disease		Tuberculosis	

10. Are there any conditions or diseases not listed above that you currently have, or have had in the past?

YES NO

If yes, please provide details.

11. Are there any diseases or medical problems that run in your family (ie: cancer, diabetes, heart disease)?

NOT SURE YES NO

If yes, please provide details.

12. Do you smoke or chew (nicotine or other products)?

YES NO

13. Are you breastfeeding?

YES

NO

14. Are you pregnant?

NOT SURE

YES

NO

15. If you are pregnant, what is your due date?

Patient Privacy

All personal information and personal health information is maintained by the University in a confidential manner at all times. The University of Western Australia (UWA) Podiatric Medicine & Surgery Discipline (PMSD) its employees, students and agents is subject to the [Privacy Act 1988](#) (the Privacy Act) and to the requirements of the [Australian Privacy Principles](#) (APPs) contained in the Privacy Act. We also adhere to the guidelines issued by the Office of the Australian Information Commissioner <https://www.oaic.gov.au/> Our **privacy policy** has been developed in accordance with the APPs and embodies our commitment to protecting personal information. Your clinical records will only be provided to others / shared with your consent (as signed below) and you have a right to request a copy of your own information at any time. It is therefore important you read the consent carefully.

THIS CONSENT GRANTS THE UNIVERSITY OF WESTERN AUSTRALIA PODIATRIC MEDICINE & SURGERY DISCIPLINE, PERMISSION TO COLLECT, USE AND DISCLOSE YOUR HEALTH INFORMATION, AS WELL AS YOUR PERSONAL DEMOGRAPHIC INFORMATION IN THE MANNER DESCRIBED BELOW.

The UWA PMSD regularly incorporates patient health information in peer-reviewed research journals, and as part of teaching and examination materials for students and health professionals. Where practicable, PMSD accepts and provides de-identified or unidentifiable information. Despite any de-identification process, complete anonymity cannot always be guaranteed. This means where particular or unique information must be featured, patients may become identifiable. In receiving your information, PMSD commit to only using it for the purposes of teaching, research, and clinical treatment, including surgical procedures and operations.

By signing below, you consent to information relating to your foot / feet conditions, such as photographic and radiographic images, as well as any recordings and demographic data, being used for research and teaching purposes.

Patient's Name	Patient / Guardian's Signature	Date
Witness Name	Witness Signature	Date

If you are unable to sign this form on your device, please return it to clinic-podiatry@uwa.edu.au and we will arrange for you to sign it at your next appointment.