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THE UNIVERSITY OF WESTERN AUSTRALIA

Patient Information

PATIENT LABEL HERE

Family Name		**Date of Birth**	
Given Names		**Country of Birth**	
Title	☐ Dr ☐ Miss ☐ Mr ☐ Mrs ☐ Ms ☐ Other _____		
Assigned sex at birth	☐ Female ☐ Male	**This information is captured on behalf of the Department of Health.**	
Gender Identity	☐ Female ☐ Male ☐ Indeterminate ☐ Prefer not to identify		
Employment Status	☐ Student ☐ Employed ☐ Retired ☐ Pensioner ☐ Other		
Marital Status	☐ Single ☐ Married/Defacto ☐ Separated/Divorced ☐ Widowed ☐ Other		
Indigenous status	☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & TSI ☐ Neither ☐ Decline to Answer		
Street Address			
Suburb		**Post Code**	
Home Telephone Number		**Mobile Number**	
Email			
Transport	☐ Car ☐ Bus ☐ Uber / Taxi ☐ Ambulance ☐ Other		
Language		**Interpreter Required?** ☐ **YES** ☐ **NO**	
Medicare Number		**Reference**	**Expiry**
Funding (please select)	Third Party / Self-Funded	Worker's Comp	Other
Private Health Fund Name		**Hospital Cover?** ☐ **YES** ☐ **NO**	
Member Number			
Source of Referral	☐ GP ☐ Specialist ☐ Outpatient ☐ Hospital ED ☐ Other		
GP's Name			
GP's Address			
Emergency contact person and phone number:			
How did you hear about us			

1. Do you have any allergies? ☐ YES ☐ NO

If yes, please provide details.

Name of any medication you are allergic to _____

2. Are you currently taking any medications? ☐ YES ☐ NO

If yes, please provide details. (Name of medication, dosage and frequency)

3. Do you drink alcohol? ☐ YES ☐ NO

If yes, how often? _____

How many standard drinks in one sitting? _____

☐ _____

4. Do you smoke or chew nicotine or other products? ☐ YES ☐ NO

5. How often do you participate in active exercise?

☐ 6–7 days ☐ 4 - 5 days ☐ 2-3 Days ☐ 1 day ☐ Seldom ☐ Never

6. 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	

7. 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.

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.