F54

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** | ☐ Woman ☐ Man ☐ Transgender ☐ Non-binary/non-conforming ☐ Prefer not to say | | |
| **Employment Status** | ☐ Student ☐ Employed ☐ Retired ☐ Pensioner ☐ Other | | |
| **Marital Status** | ☐ Single ☐ Married/Defacto ☐ Separated/Divorced ☐ Widowed ☐ Other | | |
| **Do you identify as?** | ☐ Aboriginal ☐ TSI ☐ Both Aboriginal & TSI ☐ Neither | | |
| **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 Practice Name** | | | |
| **GP's Address** | | | |

## How did you hear about us?

## Emergency contact person and phone number:

**1. An up-to-date record of your immunisation status is valuable medical information.**

## Please indicate any vaccination / immunisation you have received.

| | | | | | |
|---|---|---|---|---|---|
| COVID 1 | | COVID 2 | | COVID Booster | |
| Flu Vax | | Gardasil (1, 2, & 3) | | Hepatitis A (1 & 2) | |
| Hepatitis B (1, 2, & 3) | | Measles/Mumps/Rubella | | Pneumococcal | |
| Polio (D-TAP) | | Tetanus | | Varicella | |
| Other (list) | | Other (list) | | Other (list) | |

**2. Do you have any allergies?** ☐ YES ☐ NO

*If yes, please provide details.*

**Name of any medication you are allergic to** _____

_____

**Latex / rubber products** _____

**Other (ie: hay fever, foods)** _____

**Do you carry an Epi-pen?** ☐ YES ☐ NO

**3. Are you being treated for any medical condition at the present?** ☐ YES ☐ NO

*If yes, please provide details.*

**4. Have you been treated for any medical condition in the past year?** ☐ YES ☐ NO

*If yes, please provide details.*

**5. When was your last medical check-up?**

6. **Has there been any change in your general health in the past year?** ☐ YES ☐ NO

*If yes, please provide details.*

7. **Have you had any hospitalisations or surgeries in the past?** ☐ YES ☐ NO

*If yes, please provide details.*

8. **Are you currently taking any medications?** ☐ YES ☐ NO

*If yes, please provide details.*

9. **Do you drink alcohol?** ☐ YES ☐ NO

*If yes, please provide more detail.*

**How often do you have a drink containing alcohol?**

☐ Monthly or less ☐ 2 - 4 times / month ☐ 2 - 4 times / week ☐ more than 4 times / week

**How many standard drinks containing alcohol would you have on a typical day?**

☐ 1 – 2 drinks ☐ 3 – 4 drinks ☐ 5 - 6 drinks ☐ 7 - 9 drinks ☐ more than 10 drinks

**How often would you consume six or more drinks containing alcohol in one occasion?**

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or most days

10. **Do you smoke or chew (nicotine or other products)?** ☐ YES ☐ NO

11. **How many days per week do you usually do 10 minutes of VIGOROUS physical activity? (ie: running, swimming, aerobics, tennis, bicycle riding).**

☐ Every day ☐ 6 days ☐ 5 days ☐ 4 days ☐ 3 days ☐ 2 days ☐ 1 days ☐ Never

**How many days per week do you usually do 20 minutes of VIGOROUS physical activity?**

☐ Every day ☐ 6 days ☐ 5 days ☐ 4 days ☐ 3 days ☐ 2 days ☐ 1 days ☐ Never

**12. 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 | |

**13. 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.*

**14. 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.*

**15. Are you breastfeeding?** ☐ YES ☐ NO

**16. Are you pregnant?** ☐ NOT SURE ☐ YES ☐ NO

**17. 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.