Mr Vishal Pai
ORTHOPAEDIC KNEE SURGEON

Mr Vishal Pai
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New Patient Form

Title Please select | Given Names | Surname

Date of birth | Occupation

Telephone | Mobile | Email

Address | City | State Please select | Postcode

Emergency contact | Relationship | Mobile

Medicare number | Individual Reference Number | Expiry

Private Health Insurance Please select | Fund name | Member no.

DVA Please select | DVA no. | Please select

Referring doctor | Please select

Practice address | City | State Please select | Postcode

If the referring doctor is not your General Practitioner, please provide their details.

GP name | Practice name

Practice address | City | State Please select | Postcode

Do you currently have a regular physiotherapist you see? Please select | Physiotherapist name

Practice address | City | State Please select | Postcode

Is this case related to Workers Compensation? Please select | Claim no.

Date of injury | Employee / company name

Employee / company address | City | State Please select | Postcode

Insurance company

Insurance company address | City | State Please select | Postcode

Case manager details: Given Names | Surname

Telephone | Email

Is this case related to the Transport Accident Commission? Please select | TAC Claim no.

Date of injury

Case manager details: Given Names | Surname

Telephone | Email

Medical History

Do you take regular medications? Please select

If yes, do you regularly take: Warfarin ☐ Clopidogrel ☐ Aspirin ☐ Other blood thinners ☐

Do you regularly take herbal medications? Please select

If yes, which ones?

Do you regularly take pain medications? Please select

If yes, please specify type, quantity and frequency.

Do you drink alcohol? Please select

If yes, how many days per week?

How many drinks per day?

Do you smoke cigarettes? Please select

If yes, how many cigarettes per day?

How many years have you been smoking for?

Are you allergic to the following? Latex ☐ Iodine ☐ Chlorhexidine ☐ Dressings ☐

Please specify which ones.

Do you have drug allergies? Please select

If yes, please specify which ones and what the allergy is.

Rash ☐ Shortness of breath ☐ Swelling ☐ Anaphylaxis ☐ Other ☐

Have you had any type of previous orthopaedic surgery? Please select

If yes, please list the type of surgery and when.

Medical Checklist

Please check the boxes that apply below OR check this box if you do not have any medical problems: ☐

Cardiac

- Heart attack ☐
- High blood pressure ☐
- Low blood pressure ☐

Infections

- Hepatitis B ☐
- Hepatitis C ☐
- HIV/AIDS ☐

Respiratory

- Pulmonary embolus ☐ DVT ☐
- Asthma ☐
- Emphysema (COPD) ☐
- Obstructive sleep apnoea (CPAP) ☐

Cancer

- Breast ☐
- Lung ☐
- Prostate ☐
- Knee region ☐
- Other ☐

Endocrine

- Diabetic ☐
  - Diet ☐
  - Tablets ☐
  - Insulin ☐
- Overactive thyroid ☐
- Underactive thyroid ☐

Other

- Rheumatoid arthritis ☐
- Other inflammatory arthritis ☐
- Kidney problems ☐
- Strokes ☐
- Indigestion or reflux ☐
- Stomach ulcers ☐

Other

Please specify.