DR SAM MARTIN
SPECIALIST ORTHOPAEDIC CENTRE

Dr Sam Martin
MBBS, FRACS, FAOrthA | Orthopaedic Surgeon
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Provider No: 240628JK

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The Specialist Orthopaedic Centre
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New Patient Form

Title		Given Names			Surname		
Date of birth		Occupation					
Telephone		Mobile		Email			
Address		City		State		Postcode	
Next of Kin		Relationship			Mobile		
Medicare number			Individual Reference Number			Expiry	
Private Health		Fund name			Member no.		
DVA		DVA no.					
Referring doctor							
Practice address		City		State		Postcode	

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

GP name			Practice name				
Practice address		City		State		Postcode	

Do you currently have a regular physiotherapist you see?			Physiotherapist name				
Practice address		City		State		Postcode	

In your own words what is the problem that you are seeing Dr Martin about, how is it affecting your daily life, how long have you had this problem and is it getting better or worse?

Have you had any previous operations? If so, what and were there any problems or complications?

Medical History

Do you take regular medications?

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

Do you regularly take herbal medications?

If yes, which ones?

Do you regularly take pain medications?

If yes, please specify type, quantity and frequency.

Do you drink alcohol?

If yes, how many days per week?

How many drinks per day?

Do you smoke cigarettes?

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?

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 surgery?

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

If you are male, over 50 do you need to get up at night often to urinate?

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 ☐ Asthma ☐ DVT ☐
- 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 ☐
- Inflammatory arthritis ☐
- Kidney problems ☐
- Strokes ☐
- Indigestion or reflux ☐
- Stomach ulcers ☐

Other (please specify)