**Contact information and overview of your past medical history**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  | | | | | | Preferred Name: | |  | | |
| DOB: |  | | | | | | Age: | |  | | |
| Phone Home |  | | Phone Work | |  | | Mobile | |  | | |
| Do you give permission for messages to be left on your phone number when we are trying to contact you? | | | | | | | | | | | **YES / NO** |
| Email: | |  | | | | | | | | | |
| Address: | |  | | | | | | | | | |
| Postal Address | |  | | | | | | | | | |
| Name of next of Kin/friend: | |  | | Phone No: | |  | | Relationship to you: | |  | |
| GP/Medical Centre: | |  | | | | Occupation” | |  | | | |

**ACC Details (if applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| ACC Claim No. |  | Date of Injury: |  |
| Body Site |  | Side: |  |
| Cause of Injury |  | | |

**Insurance Details (if applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Company: |  | Membership No: |  |

**Past surgical history, please list.**

|  |
| --- |
| **Year Surgery Any complications** …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….. |

**Current medications, including vitamins, please list.** ………………………………………………………………………………………………………………………………………………………………………………………………………

Do you have any allergies: eg medications, latex or sticking plasters? Please list……………………………………………………………………………. .………………………………………………………………………………………………………………………………………………………………………………………………………

Do you smoke? **YES / NO** Do you drink alcohol? **YES / NO**

Do you have or have you ever had any of the following? Tick all that apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Anaemia** |  | **Arthritis** | | |  | **Stroke** |
|  | **Bleeding disorder** |  | **Heart disease/chest pain** | | |  | **High/low blood pressure** |
|  | **Hepatitis or HIV** |  | **Diabetes** | | |  | **Asthma/breathing problems** |
|  | **Stomach/gastrointestinal problems** | | |  | **Family history of anaesthetic problems** | | |
|  | **Family history of bleeding problems** | | |  | **Blood clots (DVT/PE)** | | |
|  | **Family history of blood clots (DVT/PE)** | | |  | **Cancer** | | |

|  |
| --- |
| **Permission to collect and store information:**  **We need to collect and store some information about you**, to help us provide good and safe treatment and to provide government bodies with information to which they are legally entitled.  **We undertake:** only to collect information which is appropriate to your total care, only to use the information for its intended purposes, to keep the information in your medical file and/or our computer system, only to allow authorised staff to use that information, only to pass on to government bodies that information to which they are legally entitled, to allow you to check the accuracy of any of the information about you and to submit written correction which you feel appropriate.  **ACC patients please be advised:**  The ACC number raised by your GP or physiotherapist does not mean ACC has approved your claim. If ACC have not written to you confirmation that your claim has been accepted, your claim may be declined. If this is the case, you will be liable to pay for any consultation or diagnostic testing, and any collection costs incurred due to the non-payment of these.  **I have read the above and agree to collection and storage of information, and that should ACC decline my claim I will be liable for any outstanding account, and any late payment fees and/or collection costs incurred as a result of non-payment.** |

**Signed: ……………………………………………………………………. Date: ………………………………**