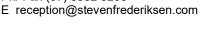
## HAND AND UPPER LIMB SURGEON

Brisbane Hand & Upper Limb Clinic 9/259 Wickham Tce Spring Hill Q 4000 Ph/ Fax (07) 3832 3203 E reception@stevenfrederiksen.com





www.stevenfrederiksen.com

PATIENT REC	GISTRATION	
Today's Date:		
Title	Dr / Mr / Mrs / Miss / Ms (please circle)	
Patient	First name (s)	Surname
Address		
Date of birth	11	Occupation
Home phone		Work
Mobile		Email
Person respor	nsible if the patient is a minor	
Medicare No .	Ref (N	o. next to your name) Exp /
Private Health	Insurance Fund	Member No
DVA No		Gold Card / White Card (please circle)
For White card	d holders, please specify cond	dition covered:
Pension No		Expiry
Family Doctor's Name & Address		
I authorise Dr Frederiksen to discuss my medical condition with the person named below in the event of an emergency or if Dr Frederiksen cannot contact me directly –		
Contact in cas	se of emergency	
Relationship .		Phone
Is this a WorkCover Claim? YES / NO (please circle)		
Employer		Insurance Company Name:
Claim No		Date of injury /

## What is the reason for today's appointment? ..... How long have you had the symptoms of this condition? ..... Do you have any current health problems? YES / NO Please list ..... Have you suffered from any serious illness in the past? YES / NO Please indicate (circle) if you have a history of the following: High blood pressure Heart problems Lung problems Bleeding tendency Epilepsy Rheumatic fever Blood disease Hepatitis Diabetes Blood clots Gastro-intestinal disorder Kidney disease What operations have you had in the past? ..... ..... Are you pregnant? YES / NO List all your current medications (diabetics please specify medication/dosage/time taken) ..... Please list any allergies that you have ..... Do you have a Latex allergy? YES / NO If yes, what reaction does this cause? ..... Do you smoke? YES / NO If so, how much do you smoke per day? ...... How long for? ..... Alcohol intake ..... standard drinks per day

Have you been tested for HIV or Hepatitis C antigen? YES / NO

If so, was the result: Positive / Negative

MEDICAL HISTORY