

PATIENT REGISTRATION & MEDICAL ASSESSMENT

Dr Farshad Ghazanfari | MD, FRACP, MSc (Sports Medicine)

Consultant Physician – General & Acute Medicine | Musculoskeletal, Sports & Integrative Medicine

Provider number: 268268VA • Date completed: ____ / ____ / ____

1. Patient details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Family name: _____

Given name(s): _____

Preferred name: _____

Date of birth: ____ / ____ / ____ Gender (optional): _____

Residential address: _____

Suburb / postcode: _____

Mobile: _____ Other phone: _____

Email: _____

Preferred language ☐ English ☐ Farsi / Persian ☐ Dari ☐ Other: _____

Interpreter required? ☐ Yes ☐ No

2. Emergency contact / next of kin

Name: _____ Relationship: _____

Phone: _____

May we discuss your healthcare with this person? ☐ Yes ☐ No ☐ Only in an emergency

3. Medicare, insurance & claim details

Medicare number: _____ IRN: _____ Expiry: _____

Private health insurer / membership number: _____

Hospital cover ☐ Yes ☐ No ☐ Unsure

Pension / Health Care Card number and expiry: _____

DVA card / number (if applicable): _____

Is this consultation related to TAC or WorkCover? ☐ Yes ☐ No

Claim number / insurer (if relevant): _____

4. Referrer and regular GP

Referring clinician and clinic: _____

Regular GP / clinic (if different): _____

GP practice phone: _____

Other treating specialists / clinicians: _____

5. Your main health concerns

What is the main problem you would like assessed? _____

When did symptoms begin? _____

Symptoms are ☐ Improving ☐ Unchanged ☐ Worsening ☐ Fluctuating

Treatments tried / what has or has not helped: _____

6. Medical history

Have you ever been diagnosed with: ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout

☐ Psoriatic arthritis ☐ Lupus ☐ Sjögren's ☐ Scleroderma

☐ Ankylosing spondylitis / axial SpA ☐ Fibromyalgia ☐ Osteoporosis

☐ Diabetes ☐ Thyroid disease ☐ High blood pressure ☐ Heart disease

☐ Stroke / TIA ☐ Asthma / COPD ☐ Kidney disease ☐ Liver disease

☐ Cancer ☐ Blood clots ☐ Anxiety / depression ☐ Other

Other diagnoses / important details: _____

7. Previous procedures, admissions and investigations

Operations and hospital admissions (with dates): _____

Relevant X-rays / MRI / CT / ultrasounds or blood tests: _____

8. Medicines, supplements and allergies

Please include prescribed medicines, over-the-counter medicines, vitamins, herbal remedies and injections.

Medication / supplement	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently take any of these? ☐ Anticoagulant ☐ Antiplatelet / aspirin ☐ Oral steroid

☐ Immunosuppressant / biologic ☐ Opioid ☐ None of these

Any medication / food / latex / adhesive / anaesthetic allergies? ☐ Yes ☐ No ☐ Unsure

Allergen and reaction (if any): _____

9. Review of systems – please tick any symptoms you have experienced

Tick "Yes" or "No" for each item. If "Yes", tell your doctor when it started and whether it is persistent or intermittent.

GENERAL

Unexplained fatigue ☐ Yes ☐ No

Unintentional weight loss ☐ Yes ☐ No

Fever or night sweats ☐ Yes ☐ No

EYES & MOUTH

- Dry or gritty eyes ☐ Yes ☐ No
- Dry mouth / needing water to swallow dry food ☐ Yes ☐ No
- Recurrent mouth or nasal ulcers ☐ Yes ☐ No
- Red or painful eyes / light sensitivity ☐ Yes ☐ No

SKIN, HAIR & CIRCULATION

- Hair thinning / excess hair loss ☐ Yes ☐ No
- Psoriasis or scaly skin rash ☐ Yes ☐ No
- Rash worsening in sunlight ☐ Yes ☐ No
- Thickening or tightening of skin ☐ Yes ☐ No
- Fingers turning white, blue or red in cold or stress (Raynaud's) ☐ Yes ☐ No
- Persistent finger sores / ulcers ☐ Yes ☐ No
- Nail pitting / nail changes ☐ Yes ☐ No

JOINTS, MUSCLES & BACK

- Swollen joints ☐ Yes ☐ No
- Warm / red joints ☐ Yes ☐ No
- Morning stiffness longer than 30 minutes ☐ Yes ☐ No
- Back pain improving with movement / waking you at night ☐ Yes ☐ No
- Heel / tendon insertion pain ☐ Yes ☐ No
- Entire swollen finger / toe (dactylitis) ☐ Yes ☐ No
- Muscle weakness ☐ Yes ☐ No
- Muscle aches ☐ Yes ☐ No

HEART & LUNGS

- Chest pain ☐ Yes ☐ No
- Breathlessness ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Leg swelling ☐ Yes ☐ No
- Persistent cough ☐ Yes ☐ No
- Coughing blood ☐ Yes ☐ No

GASTROINTESTINAL

- Difficulty swallowing / reflux ☐ Yes ☐ No
- Abdominal pain ☐ Yes ☐ No
- Persistent diarrhoea or constipation ☐ Yes ☐ No
- Blood in stool ☐ Yes ☐ No

URINARY / REPRODUCTIVE

- Blood in urine ☐ Yes ☐ No
- Painful urination ☐ Yes ☐ No
- Urinary frequency / leakage ☐ Yes ☐ No
- Menstrual or pelvic symptoms (if relevant) ☐ Yes ☐ No

NERVES & MOOD

- Numbness / tingling ☐ Yes ☐ No
- Headaches / dizziness ☐ Yes ☐ No
- Fainting ☐ Yes ☐ No
- Sleep disturbance ☐ Yes ☐ No
- Anxiety or low mood ☐ Yes ☐ No

OTHER IMMUNE / BLOOD

Easy bruising / bleeding ☐ Yes ☐ No

Unexplained blood clots ☐ Yes ☐ No

Recurrent infections ☐ Yes ☐ No

Enlarged glands ☐ Yes ☐ No

Additional symptoms / details: _____

10. Family and social history

Family history of arthritis, autoimmune disease, psoriasis, gout, osteoporosis, heart disease or cancer:

Smoking / vaping ☐ Never ☐ Former ☐ Current

If current/former, amount and duration: _____

Alcohol ☐ None ☐ Occasional ☐ Weekly ☐ Daily

Usual activity / exercise, work demands and hobbies: _____

Are you pregnant, planning pregnancy or breastfeeding? (if relevant) ☐ Yes ☐ No ☐ Not applicable

11. Function, pain and wellbeing

How much do symptoms interfere with your day? ☐ Not at all ☐ A little ☐ Moderately ☐ Severely

Pain over the past week (0 = no pain, 10 = worst possible pain): ____ / 10

Fatigue over the past week (0 = none, 10 = extreme): ____ / 10 _____

How long does morning stiffness last? _____ minutes / hours / not applicable

How have symptoms affected your work, sleep or personal care?

12. Functional ability questionnaire (past seven days)

Please choose ONE response per activity: 0 = No difficulty | 1 = Some difficulty | 2 = Much difficulty | 3 = Unable to do.

Domain	Activity	0	1	2	3
Dressing	Dress yourself (buttons and shoelaces)	☐	☐	☐	☐
Dressing	Shampoo your hair	☐	☐	☐	☐
Rising	Stand from a straight chair	☐	☐	☐	☐
Rising	Get in and out of bed	☐	☐	☐	☐
Eating	Cut food	☐	☐	☐	☐
Eating	Lift a full cup or glass	☐	☐	☐	☐
Eating	Open a new milk carton	☐	☐	☐	☐
Walking	Walk on level ground outdoors	☐	☐	☐	☐
Walking	Climb five steps	☐	☐	☐	☐
Hygiene	Wash and dry your body	☐	☐	☐	☐
Hygiene	Take a bath or shower	☐	☐	☐	☐

Hygiene	Get on and off the toilet	☐	☐	☐	☐
Reach	Reach up to take down a 2.3 kg object	☐	☐	☐	☐
Reach	Bend to pick up clothes	☐	☐	☐	☐
Grip	Open car doors	☐	☐	☐	☐
Grip	Open a previously opened jar	☐	☐	☐	☐
Grip	Turn taps on and off	☐	☐	☐	☐
Activities	Shop / run errands	☐	☐	☐	☐
Activities	Get in and out of a car	☐	☐	☐	☐
Activities	Do housework or gardening	☐	☐	☐	☐

13. Mobility aids and assistance

Do you use any aids? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Raised toilet seat

☐ Shower chair / grab rail ☐ Adapted utensils ☐ Dressing aids ☐ Other

Other aids / equipment: _____

Do you need another person to help with: ☐ Dressing ☐ Rising ☐ Eating ☐ Walking

☐ Bathing / toileting ☐ Reaching ☐ Grip / opening objects ☐ Shopping / chores

14. Overall health assessment

Everyday physical activities (walking, stairs, carrying shopping, moving a chair):

Ability ☐ Completely ☐ Mostly ☐ Moderately ☐ A little ☐ Not at all

Overall pain in the past week (0 = none; 100 = severe): _____ / 100

Overall health (0 = very well; 100 = very poor): _____ / 100 _____

15. Communication and consent

To coordinate my care, I consent to the clinic collecting and using the health information I provide and, where reasonably necessary for my healthcare, sharing relevant information with my GP, referring doctor, specialists, hospitals, pathology or imaging providers and other treating healthcare professionals, subject to applicable privacy law.

Consent to relevant care-related information sharing: ☐ Yes ☐ No – please discuss with clinician

I understand that I can ask questions about how my information is managed and can request that particular providers or information not be shared where clinically and legally practicable. This section is not a substitute for consent to an individual procedure.

Information-sharing restrictions / preferences: _____

May the clinic contact my other treating providers to request clinically relevant records? ☐ Yes ☐ No – discuss first

Preferred routine contact method ☐ Phone ☐ SMS ☐ Email

I confirm that the information supplied is accurate to the best of my knowledge and that I will tell the clinic about important changes.

Patient name: _____

Patient / representative signature: _____ Date: ____ / ____ / ____

Representative name / relationship (if applicable): _____

Clinic note: Clinical screening responses are not diagnoses. Functional items are adapted for intake and should not be treated as a validated HAQ-DI score.