DR FARSHAD GHAZANFARI MD. FRACP, Msc Sports Medicine
Consultant Physician in Acute Care & General Medicine
Interest in Rheumatology & Musculoskeletal Medicine
Provider # 268268VA

PATIENT REGISTRATION

Date Completed ___ / ___ / _____

PERSONAL INFORMATION

Title: Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Dr ❑ Other ……

SURNAME: …… First Name: ……

Address: ……

……

Date of Birth: ……/……/…… Email Address: ……

Phone: Home …… Mobile: ……

NEXT OF KIN

Name: …… Relationship: ……

Contact Home: …… Mobile: ……

Permission to release medical information to next of Kin Yes ❑ No ❑

FINANCIAL INFORMATION

Medicare Number: …… / …… / …… No, next to your Name : …… Exp……

Private Health Fund: ……Membership #: ……

Hospital Cover: Yes ❑ No ❑ Unsure ❑

Pension / HCC : …… Expiry: ……

DVA: Gold ❑ White ❑ Number: ……

TAC / Workcover Yes ❑ No ❑ Claim #: ……

REFERRING DOCTOR

Doctors Name: ……

Address: ……

Is this your regular General Practitioner: Yes ❑ No ❑

If No, Regular GP ……

Clinic: …… Phone: ……

Other interested parties: ……

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Authority for us to provide your information to necessary health care providers.

I authorise Dr Ghazanfari to provide information about my personal health care to other health care providers for the purpose of optimising my health care management. Dr Ghazanfari will maintain ownership of this information and will release only such information as is deemed relevant for care provision.

Exclusions (if any):

Patient Name: ……

Signature: ……..……

Date: ……..

Authority to release personal information to us.

I authorise Dr Ghazanfari to obtain all medical and other information required for my care.

I consent to the release of medical, clinical or other information by any medical practitioner, hospital, clinic, insurance company, Centrelink, the Department of Defence or other organisation that would appear to be relevant Dr Ghazanfari.

I understand that by signing this form it will mean that Dr Ghazanfari and his delegates will be able to ask any person who holds information about you to disclose that information, if that information seems relevant to providing my medical care.

In general, this form will be used to access your medical records in the possession of other Doctors and hospitals.

Exclusions (if any): ……..

Patient Name: ……

Signature: ……

Date: ……..

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Name: _____

MEDICAL HISTORY

Do you have any of the following (if YES, please tick appropriate box):

GENERAL
- ❑ Fatigue
- ❑ Weight loss > 5kg
- ❑ Cancer

SKIN
- ❑ Nail changes
- ❑ New Lesions
- ❑ Rash
- ❑ Skin Colour Changes

HEENT
- ❑ Double Vision
- ❑ Eye Pain
- ❑ Eye Redness
- ❑ Ear Ringing
- ❑ Nose Bleeds
- ❑ Dry Mouth
- ❑ Hoarseness
- ❑ Oral Ulcers
- ❑ Sore Throat
- ❑ Swollen Glands

MUSCULOSKELETAL
- ❑ Decreased Range of Motion
- ❑ Neck Pain
- ❑ Joint Pain
- ❑ Joint Redness
- ❑ Joint Swelling
- ❑ Joint Stiffness
- ❑ Muscle Weakness
- ❑ Muscle Aches/Pains
- ❑ Lupus
- ❑ Psoriasis
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis

RESPIRATORY
- ❑ Chronic Cough
- ❑ Decreased Exercise Tolerance
- ❑ Difficulty Breathing
- ❑ Coughing Up Blood
- ❑ Sputum Production
- ❑ Wheezing
- ❑ Pulmonary Embolism

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Cardiac Leg Pains with walking
- ❑ Leg Swelling
- ❑ Night Awakening Due to trouble Breathing
- ❑ Palpatations
- ❑ Shortness of breath
- ❑ Pacemaker

GASTROENTEROLOGY
- ❑ Abdominal Pain
- ❑ Change in Bowel Habits
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting
- ❑ Hepatitis
- ❑ Rectal Bleeding
- ❑ Trouble Swallowing

HEAMATOLOGY
- ❑ Easy Bruising
- ❑ Enlarged Lymph Nodes
- ❑ Prolonged Bleeding
- ❑ Anemia
- ❑ Blood Clots
- ❑ Hepatitis / HIV

GENITOURINARY
- ❑ Menstrual Irregularities
- ❑ Difficulty Starting/Stopping urinary stream
- ❑ Painful Urination
- ❑ Change in Urinary Stream
- ❑ Increased Frequency
- ❑ Blood in Urine
- ❑ Loss of Bladder Control
- ❑ Night time Urination
- ❑ Urinary Retention
- ❑ Urethral Discharge
- ❑ Kidney Stones

NEUROLOGICAL
- ❑ Loss of Bowel Control
- ❑ Dizziness/Vertigo
- ❑ Headaches
- ❑ Numbness/Tingling
- ❑ Passing Out
- ❑ Seizures
- ❑ Tremor
- ❑ Stroke

PSYCHIATRIC
- ❑ Anxiety
- ❑ Change in Sleep Pattern
- ❑ Depression
- ❑ Hallucinations
- ❑ Suicidal Thoughts

ENDOCRINE
- ❑ Appetite Changes
- ❑ Cold Intolerance
- ❑ Diabetes
- ❑ Increased Thirst
- ❑ Increased Urination
- ❑ Hair Thinning
- ❑ Thyroid problems

Other……

……

……

FAMILY HISTORY

Do you have a family history of any of the conditions listed on the previous page?

……

……

……

……

ALLERGIES

Are you allergic to any medications, tapes, dressing, anaesthetics, lotions or foods? (Please list)

……

……

……

Current Medications (Prescription + Non Prescription)

Do you take: Warfarin Plavix / Iscover Aspirin Prednisolone

Other: Please List: ……

……

……

……

The information listed above enables our Physician to provide the best patient care possible. This information is treated as STRICTLY CONFIDENTIAL and will not be disclosed unless prior consent is obtained from the patient.

Patient Signature: …… Date: ……

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HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name: _____

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	❑	❑	❑	❑
Shampoo your hair?	❑	❑	❑	❑
ARISING				
Are you able to:				
Stand up from a straight chair?	❑	❑	❑	❑
Get in and out of bed?	❑	❑	❑	❑
EATING				
Are you able to:				
Cut your own meat?	❑	❑	❑	❑
Lift a full cup or glass to your mouth?	❑	❑	❑	❑
Open a new milk carton?	❑	❑	❑	❑
WALKING				
Are you able to:				
Walk outdoors on flat ground?	❑	❑	❑	❑
Climb up five steps?	❑	❑	❑	❑

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

- ❑ Walker
- ❑ Crutches
- ❑ Wheelchair
- ❑ Devices used for Dressing (button hook, zipper pull, etc.)
- ❑ Built up or special utensils
- ❑ Cane
- ❑ Special or built up chair

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

❑ Dressing and grooming ❑ Arising ❑ Eating ❑ Walking

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
HYGIENE **Are you able to**:				
Wash and dry your body?	❑	❑	❑	❑
Take a tub bath?	❑	❑	❑	❑
Get on and off the toilet?	❑	❑	❑	❑
REACH **Are you able to**:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	❑	❑	❑	❑
Bend down to pick up clothing from the floor?	❑	❑	❑	❑
GRIP **Are you able to**:				
Open car doors?	❑	❑	❑	❑
Open previously opened jars?	❑	❑	❑	❑
Turn faucets on and off?	❑	❑	❑	❑
ACTIVITIES **Are you able to**:				
Run errands and shop?	❑	❑	❑	❑
Get in and out of a car?	❑	❑	❑	❑
Do chores such as vacuuming or yard work?	❑	❑	❑	❑

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

❑ Raised toilet seat ❑ Bathtub bar ❑ Long-handled appliances for reach

❑ Bathtub seat ❑ Long-handled appliances in bathroom ❑ Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

❑ Hygiene ❑ Reach ❑ Gripping and opening things ❑ Errands and chores

Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY	MOSTLY	MODERATELY	A LITTLE	NOT AT ALL
❑	❑	❑	❑	❑

Your PAIN: How much pain have you had IN THE PAST WEEK?

On a scale of 0 to 100 (where zero represents "no pain" and 100 represents "severe pain"), please record the number below.

Your HEALTH: Please rate how well you are doing.

On a scale of 0 to 100 (0 represents "very well" and 100 represents "very poor" health), please record the number below.
