DR BOB JANG

Orthopaedic Surgeon

DATE:___________________

PATIENT INFORMATION SHEET

NAME:__________________________ **DATE OF BIRTH:**_____________ **AGE:**______
OCCUPATION:________________________
REFERRING DOCTOR: _________________________ **PHYSIOTHERAPIST:**________________________

Are you RIGHT/LEFT handed? RIGHT / LEFT / AMBIDEXTROUS

My MAIN problem is: PAIN / LOSS OF FUNCTION / WEAKNESS / STIFFNESS

How LONG have you had the symptoms?____________________ weeks / months / years

Was there an injury? YES / NO Date of injury:__________________
What happened?:____
Have you had Xrays/ultrasounds/CT/MRI? YES / NO Which radiology centre?______________________

PAIN
Duration: Constant / Intermittent / Certain movements
Interferes with sleep: YES / NO
Do you need to take painkillers? YES / NO

Do you have difficulty with: (Please tick)

- Overhead tasks
- Driving
- Getting dressed
- Hobbies (eg gardening)
- Playing sports
- Doing up a bra/ reaching for your wallet in your pocket

Please circle any treatment you have had already:
Physiotherapy / Pain medication / Steroid/cortisone injections

Do you smoke? YES / NO How much?________

General medications (please tick)

- Diabetes
- Stroke
- Epilepsy
- Kidney disease
- Hypertension
- Hepatitis
- Thyroid disease
- Depression
- Cancer
- Heart attack/ischaemic heart disease
- Pacemaker
- Mental illness
- Asthma/Bronchitis
- Hiatus hernia/ulcers
- Prosthetic heart valve

Circle if you take any of the following:
Warfarin / Steroids / Aspirin / Anti-inflammatories

Any allergies to medications? YES / NO

Which medications are you allergic to?____

Please list your regular medications

____
____
____

admin@DrBobJang.com.au www.DrBobJang.com.au
PO BOX 858, Leichhardt, NSW, 2040
(02) 8078 0633
Suite 209, Level 2 Strathfield Plaza
11 The Boulevarde
Strathfield NSW 2135

FAORTHA
FELLOW of the AUSTRALIAN ORTHOPAEDIC ASSOCIATION

Fellow of the Royal Australasian College of Surgeons