Edinburgh Orthopaedic Specialists

Partners:

Paul Gaston FRCSEd (Orth) • **Graham M Lawson** FRCSEd (Orth) • **James T Patton** FRCSEd (Orth) • **Daniel E Porter** FRCSEd (Orth)
Iain H Annan FRCSEd (Orth) •**Richard Burnett** FRCSEd (Orth) • **Julie M McBirnie** FRCSEd (Orth) • **Frazer A Wade** FRCSEd (Orth)

Registered Office
2 Millar Crescent
morningside
edinburgh
eh10 5hw

Practice Manager: Mrs D Christie
Email: enquiries@edinburghorthopaedics.com
Telephone: 0131 446 3048
Fax: 0131 447 5778

Patient History Form – Please Complete and Bring to Your Consultation

General Practitioner DETAILS

Name:
Practice:
Address:

Phone:
Fax:

REFERRING Practitioner DETAILS – if not GP

Name:
Practice:
Address:
Phone:
Fax:
Email:

PATIENT DETAILS:

Surname:(Mr/Mrs/Ms/Miss)_____
Given Name: _____
(Previous name: _____)
DOB: _____/_____/_____ Sex: M / F
Address:_____
_____
_____ ____
Phone: _____Mob:_____
Email: _____

Occupation: _____
Self funding or Insured ----------
Date of referral:_____/_____/_____

Preferred Consultant / Next available

_____

Current Problem:

History of Problem – Including onset and treatment received

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Employment and Recreational Activities

_____

_____

MEDICATIONS (attach list if needed)**:** **DOSE:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____

RELEVANT PAST Hx. (include allergies, previous surgery etc)**:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please complete this form where possible and bring to your consultation