NEW PATIENT REGISTRATION

Ralph Mobbs
BSc MB BS MS FRACS
Neurosurgeon
2135137T / 213513AA

Randwick
Suite 3, Level 7, POW Private
Bowral
21 St Jude St, Bowral

Title Mr / Mrs / Ms / Miss / Master / Dr

Surname ..... **Given Names** .....

Address .....

..... Postcode .....

Date of Birth ..... Age .....

Occupation .....

Telephone **H**..... **M**..... **W**.....

Next of Kin: ..... Tel:.....

Referring Dr .....

Address .....

.....

Private Insurance YES / NO Fund: .....

Membership No. ..... Longer than 12 months? Yes / No

Medicare Number .....

Veterans Affairs YES / NO Gold / Blue / White No: .....

Work cover / Third party / Public liability (please circle one) YES / NO

Has liability been accepted for this injury? YES / NO Date of injury:.....

Employer ..... Insurance Co..... Claim No: .....

Contact person: ..... Address ..... Tel: ..... Fax: .....

- Please fill out form as best you can.
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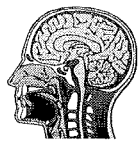

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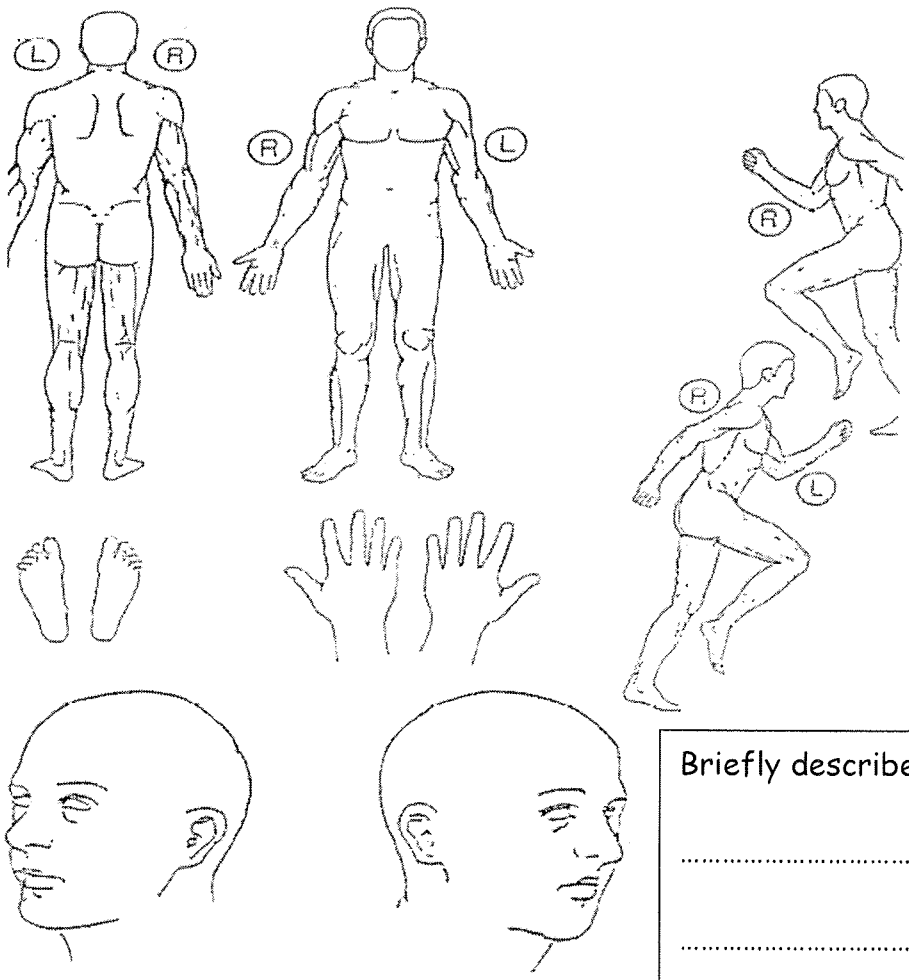
Your main problem!

Highlight on the pictures where your problem is...



Briefly describe your problem....

.....

.....

.....

Indicate current level of pain on the following scale (circle):

No Pain 0 1 2 3 4 5 **6 7 8 9 10** Intolerable Pain

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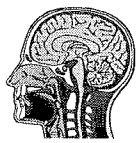

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General health information.

Do you take **blood thinning** medications? YES / NO (eg: aspirin, warfarin, clopid, NSAIDs)

Allergies? YES / NO List: .....

Have you ever had surgery on your **back or neck** before? YES / NO

Have you ever had surgery on your **head or brain** before? YES / NO

List any **previous back or head** surgery with dates and surgeon:

Operation:	Date:	Surgeon:
.....	.....	.....
.....	.....	.....

Please indicate (**circle**) if you suffer any of the following medical problems:

High blood pressure	Heart Attack/s	Angina
Diabetes Type 1 (juvenile)	Diabetes Type 2 (mature)	Lung problems
Heart surgery	Heart stent	Strokes
DVT (blood clot in legs)	Kidney problems	Liver disease
HIV	Hepatitis B or C	Long standing infections
Cancer of any type	Radiotherapy	Chemotherapy
Depression	Migraine	Siezures
Gastric ulcers	Reflux	Constipation

Do you **smoke**? YES / NO How much per day:.....

Do you **drink alcohol**? YES / NO How much per day:.....

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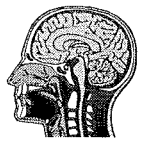

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SF-8™ Health Survey

This survey asks for your views about your health. Please **circle** your response.

1. Overall, how would you **rate your health** during the past 4 weeks?

Excellent *Very good* *Good* *Fair* *Poor* *Very poor*

2. During the past 4 weeks, how much did **physical health problems** limit your usual physical activities (such as walking or climbing stairs)?

Not at all *Very little* *Somewhat* *Quite a lot* *Could not do physical activities*

3. During the past 4 weeks, how much difficulty did you have doing your **daily work**, both at home and away from home, because of your physical health?

None at all *A little bit* *Some* *Quite a lot* *Could not do daily work*

4. How much **bodily pain** have you had during the past 4 weeks?

None *Very mild* *Mild* *Moderate* *Severe* *Very Severe*

5. During the past 4 weeks, how much **energy** did you have?

Very much *Quite a lot* *Some* *A little* *None*

6. During the past 4 weeks, how much did your physical health or emotional problems limit your usual **social activities** with family or friends?

Not at all *Very little* *Somewhat* *Quite a lot* *Could not do social activities*

7. During the past 4 weeks, how much have you been bothered by **emotional problems** (such as feeling anxious, depressed or irritable)?

Not at all *Slightly* *Moderately* *Quite a lot* *Extremely*

8. During the past 4 weeks, how much did personal or emotional problems keep you from doing your **usual work**, school or other daily activities?

Not at all *Very little* *Somewhat* *Quite a lot* *Could not do daily activities*

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