NEW PATIENT REGISTRATION

ralph mobbs
BSc MB BS MS FRACS
neurosurgeon
Prov 2135137T

p 9650 4855 f 9650 4902
suite 3, level 7
prince of wales private hospital
randwick, 2031

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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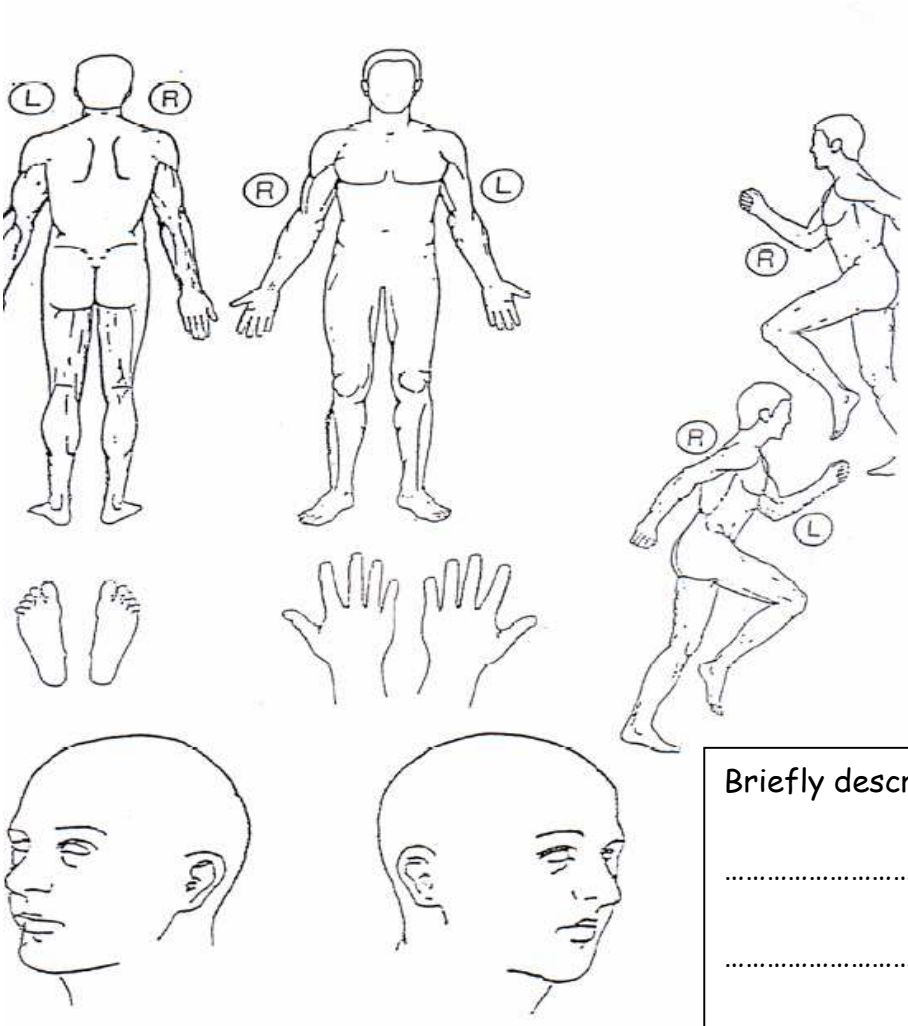
Your main problem!

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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General health information.

Please list the **medications** you are taking:

Name:	Dose:	Frequency:
……	……...	……
……	……...	……
……	……...	……
……	……...	……
……	……...	……
……	……...	……
……	……...	……

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:
……..	……..	……
……..	……..	……
……..	……..	……
……..	……..	……

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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:……

Do you take any **drugs/stimulants**? YES / NO

Are you currently receiving **treatment**s by any of the following:

Physiotherapist	Chiropractor	Osteopath
Acupuncture	Herbalist	Massage therapy
Hydrotherapy	Traction	Psychologist

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Is there any other **information about yourself** that you would like us to know?

…….

…….

List any **doctors** you are seeing with address and contact details:

…….

…….

…….

Are there any **other health care providers** (say, physio or chiro) that you would like correspondence to be sent to?

…….

…….

What are the **main questions** you would like answered today (eg: why am I in pain?, what are my options for treatment?, will this get better by itself?, what are the risks of surgery?, should I see anyone else about this problem?,)

1. …….
2. …….
3. …….
4. …….

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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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Please sign below:

- I have filled this form out honestly and to the best of my knowledge.
- I understand that my details will be kept confidential as per the Privacy Act.
- I agree to pay the quoted consultation fees for this service.
- I will pursue a second opinion if I am unhappy with the advice and management options that will be discussed / presented to me.
- I understand two people with the same disorder may be managed differently because of differences in severity of symptoms and other medical factors that are unique to each person.

Signed:…… Date:……..

- Please fill out form as best you can.
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