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Adult & Paediatric Spine Surgeon

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Orthopaedic & Spine Surgeon

OFFICE USE ONLY
 Date: _____
 Weight: _____
 Height: _____
 B/P: _____
 HR: _____
 Temp: _____

PATIENT REGISTRATION FORM

Mr/Mrs/Ms/Miss/Master/Dr/Other: _____

Family Name: _____ First Name: _____ Middle Name(s): _____

Full Name of Parent in the case of minors: _____

Address: _____

Suburb: _____ Postcode: _____ Email: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Sex: _____ Age: _____ Date of Birth: _____ Occupation: _____

NEXT OF KIN

Name: _____ Relationship: _____ Tel No: _____

Private Health Insurance: Yes No Health Fund Name: _____ HF Number: _____

Aged Care Pensioner: Yes No Pension Number: _____ Expiry Date: _____

Medicare Number: _____ Position on Card: _____ Veterans Affairs Care No: _____

Referring Dr's Name: _____

Referring Dr's Address: _____

General Practitioner's Name: _____

GP's Address: _____

GP Tel number: _____

WORKERS COMPENSATION CLAIM (complete this box for workers comp claims only)

Employer (if applicable): _____ Date of injury: _____

Employer's Address: _____ Phone: _____

Solicitors Name & Address (if applicable) _____

Insurance Company Name & Address: _____ Claim No: _____

Name of Case Manager: _____ Case Mgr Tel: _____ Fax: _____

CHIEF COMPLAINT: Please tick Yes or No

DO YOU HAVE?	Yes	No	Any other complaints: _____
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	If more than one area, which is worse? _____
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	How long have you had this problem? _____
Arm pain	<input type="checkbox"/>	<input type="checkbox"/>	Did your symptoms follow an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	If yes <input type="checkbox"/> At work <input type="checkbox"/> Auto accident <input type="checkbox"/> Other
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Please describe what happened: _____
Hip/Leg pain	<input type="checkbox"/>	<input type="checkbox"/>	_____

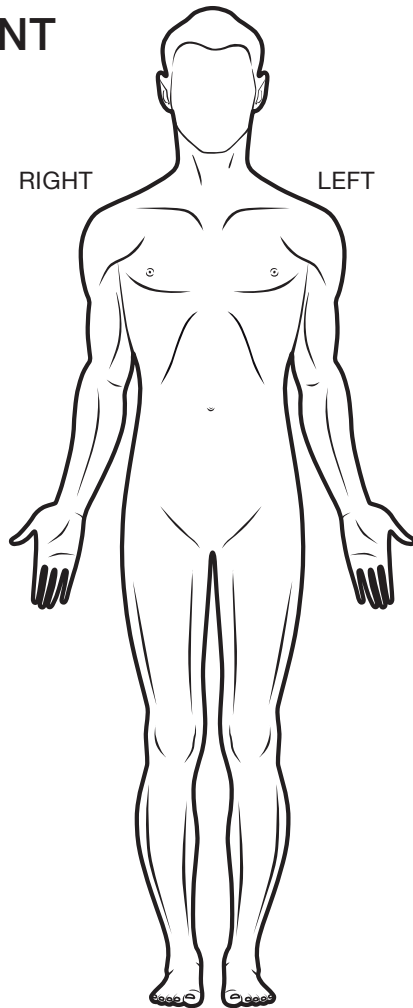
Mark in the areas of your body where you now feel your typical pain. Include all affected areas.

Use the appropriate symbols indicated below:

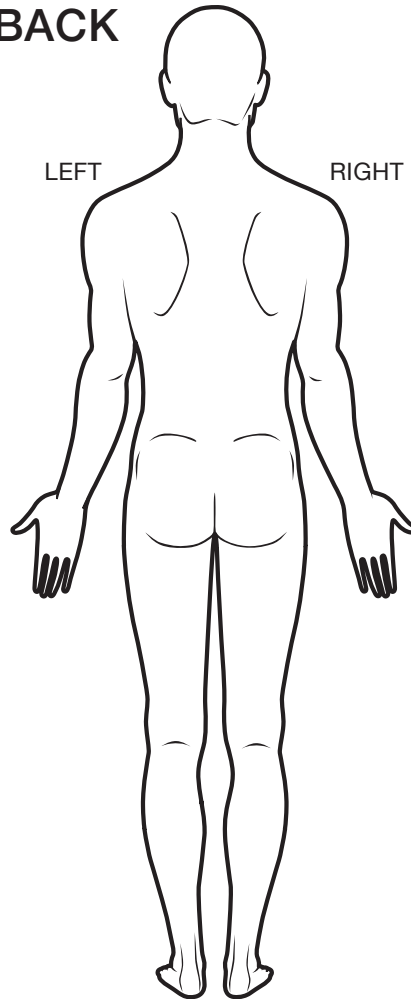
PAIN = XXXXXXXX

NUMBNESS = OOOOOOOO

FRONT



BACK



Circle your pain levels over the past two weeks:

BACK PAIN

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

LEG PAIN

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

NECK PAIN

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

ARM PAIN

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

DESCRIBE YOUR PAIN (tick ALL that apply)

- Constant Deep Dull Sharp Intermittent Throbbing
- Stiffness Aching Shooting Cramp Burning Stabbing

PREVIOUS TREATMENT:

	Tick if you have had this	Did it make things:				Tick if you have had this	Did it make things:		
		BETTER	WORSE	NO CHANGE		BETTER	WORSE	NO CHANGE	
Bed Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pool Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ice packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yoga/Tai-Chi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Braces/Splints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chiropractic Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TENS/Electrical Stim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

REVIEW OF SYSTEMS: Tick all conditions you are **currently** experiencing.

- | | | | |
|--|--|---|---|
| <p>Constitutional</p> <input type="checkbox"/> Fever
<input type="checkbox"/> Chills
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weight loss
<input type="checkbox"/> Loss of appetite | <p>Allergy/Immune</p> <input type="checkbox"/> Drug allergy
<input type="checkbox"/> Seasonal allergy
<input type="checkbox"/> Food allergy
<input type="checkbox"/> Iodine allergy
<input type="checkbox"/> Transplant | <p>Neurologic</p> <input type="checkbox"/> Paralysis
<input type="checkbox"/> Tremors
<input type="checkbox"/> Spasticity
<input type="checkbox"/> Seizures
<input type="checkbox"/> Muscle atrophy
<input type="checkbox"/> Double vision | <p>Musculoskeletal</p> <input type="checkbox"/> Joint stiffness/swelling
<input type="checkbox"/> Muscle pain/swelling
<input type="checkbox"/> Muscle fatigue
<input type="checkbox"/> Fractures |
| <p>Hemo-lymphatic</p> <input type="checkbox"/> Anemia
<input type="checkbox"/> Excessive bleeding
<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Leukemia
<input type="checkbox"/> Cancer
<input type="checkbox"/> Lymph node swelling | <p>CV/Respiratory</p> <input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Cough
<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Chest pains
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Leg swelling | <p>Gastrointestinal</p> <input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhoea
<input type="checkbox"/> Blood in stools
<input type="checkbox"/> Stomach pain | <p>Endocrine</p> <input type="checkbox"/> Obesity
<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Menopause
<input type="checkbox"/> Menstrual irregularities
<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Addison's disease |
| <p>HENT</p> <input type="checkbox"/> Loss of vision
<input type="checkbox"/> Eye redness
<input type="checkbox"/> Headness
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Glaucoma | <p>Skin/integumentary</p> <input type="checkbox"/> Rash
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Eczema
<input type="checkbox"/> Hives
<input type="checkbox"/> Sexual difficulties | <p>Psychiatric</p> <input type="checkbox"/> Poor sleep
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Stress at work/home | <p>Genitourinary</p> <input type="checkbox"/> Pain urinating
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Dribbling
<input type="checkbox"/> Pregnant
<p style="text-align: right; font-size: small;">If pregnant, date of last period</p> <hr style="width: 100%;"/> |

PAST SURGICAL HISTORY:

YEAR	OPERATION	PLACE HOSPITALISED

If you had **previous SPINAL SURGERY**, what were your symptoms before the surgery? Please describe:

Did your symptoms improve after surgery? _____ If yes, how long afterwards? _____

Did you get worse after surgery? _____ If yes, explain: _____

Were you released back to work after surgery? _____ If yes, when: _____

MEDICAL HISTORY: Have you ever had.... (tick all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma/Breathing problems
<input type="checkbox"/> Cancer
<input type="checkbox"/> Radiation/Chemotherapy
<input type="checkbox"/> Migrane/other severe head pain
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> AIDS or HIV
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Seizures | <input type="checkbox"/> Phlebitis or blood clots
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid trouble
<input type="checkbox"/> Kidney infections
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hepatitis | <p>Other current or past medical problems:</p> <hr/> <hr/> <hr/> <hr/> <hr/> |
|--|--|--|

ALLERGIES:

NAME OF MEDICINE/SUBSTANCE	TYPE OF REACTION	DATE (if known)

PREVIOUS INVESTIGATIONS & TREATMENT

Please list previous radiology studies you have had for your current spinal problem

DATES		DATES	
MRI _____	Bone Mineral Density Scan _____		
CT Scan _____	EMG/Nerve Conduction Studies _____		
XRays _____	Bone Scan _____		

MEDICINES: List all medicines that you take, including the doses and how often you take them. **Include vitamins & non-prescription medicine.**

1. _____	8. _____
2. _____	9. _____
3. _____	10. _____
4. _____	11. _____
5. _____	12. _____
6. _____	13. _____
7. _____	14. _____

If you require more room for listing your medications, please turn this page over and use the blank page on the reverse.

FAMILY HISTORY: Does anyone in your family **apart from you** suffer from any of the following conditions? Please tick/describe relevant ones.

<input type="checkbox"/> Spinal Problems	Please describe: _____
<input type="checkbox"/> Bleeding Disorders	Please describe: _____
<input type="checkbox"/> Heart Disease	Please describe: _____
<input type="checkbox"/> Cancer	Please describe: _____
<input type="checkbox"/> Diabetes	Please describe: _____

SOCIAL HISTORY:

Marital Status: Single Married DeFacto Divorced Widowed Separated

Number of children: _____ Age(s): _____

Who lives with you at home? _____

Work Status: Working Not working Homemaker Student Disabled Retired

Primary Occupation (or previous if not working/retired): _____

If not working, last date worked: _____

How long have you worked at your present job: _____ Approximate number of hours per week: _____

Spouse's Occupation: _____

Do you currently use tobacco? Yes No Type/Amount per day: _____ Years smoking: _____

Have you ever used tobacco? Yes No Type/Amount per day: _____ Years: _____ If quit, when? _____

Amount of alcohol consumed in a typical week: _____

Recreational Drug use? Yes No

Do you participate in any regular exercise? Yes No

Please describe: _____

