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 space please write on a blank sheet of paper and attach

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

- ☐ Spinal Problems — Please describe: _____
- ☐ Bleeding Disorders — Please describe: _____
- ☐ Heart Disease — Please describe: _____
- ☐ Cancer — Please describe: _____
- ☐ 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: _____

NEW SOUTH WALES SPINE Specialists

Dr Brian Hsu MBBS MMed FRACS(Orth) FAOrthA
Adult & Paediatric Spine Surgeon

Dr Bhisham Singh MBBS MS FRCS(Eng) FRACS
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
Neck pain	☐	☐
Shoulder pain	☐	☐
Arm pain	☐	☐
Upper back pain	☐	☐
Low back pain	☐	☐
Hip/Leg pain	☐	☐

Any other complaints: _____

If more than one area, which is worse? _____

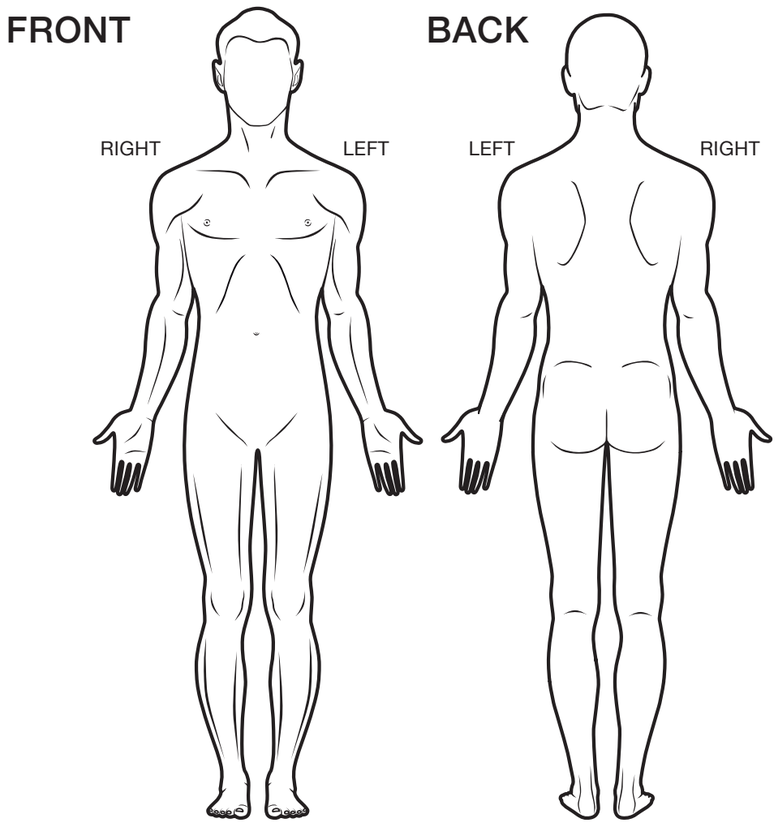
How long have you had this problem? _____

Did your symptoms follow an injury? ☐ Yes ☐ No

If yes ☐ At work ☐ Auto accident ☐ Other

Please describe what happened: _____

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**



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

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

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Weight loss
- ☐ Loss of appetite

Allergy/Immune
- ☐ Drug allergy
- ☐ Seasonal allergy
- ☐ Food allergy
- ☐ Iodine allergy
- ☐ Transplant

Neurologic
- ☐ Paralysis
- ☐ Tremors
- ☐ Spasticity
- ☐ Seizures
- ☐ Muscle atrophy
- ☐ Double vision

Musculoskeletal
- ☐ Joint stiffness/swelling
- ☐ Muscle pain/swelling
- ☐ Muscle fatigue
- ☐ Fractures

Hemo-lymphatic
- ☐ Anaemia
- ☐ Excessive bleeding
- ☐ Easy bruising
- ☐ Lymphoma
- ☐ Leukaemia
- ☐ Cancer
- ☐ Lymph node swelling

CV/Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Chest pains
- ☐ Palpitations
- ☐ Leg swelling

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Blood in stools
- ☐ Stomach pain

Endocrine
- ☐ Obesity
- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ Menopause
- ☐ Menstrual irregularities
- ☐ Pelvic pain
- ☐ Addison's disease

HENT
- ☐ Loss of vision
- ☐ Eye redness
- ☐ Headaches
- ☐ Dizziness
- ☐ Glaucoma

Skin/integumentary
- ☐ Rash
- ☐ Ulcer
- ☐ Eczema
- ☐ Hives
- ☐ Sexual difficulties

Psychiatric
- ☐ Poor sleep
- ☐ Depression
- ☐ Anxiety
- ☐ Stress at work/home

Genitourinary
- ☐ Pain urinating
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Dribbling
- ☐ Pregnant

If pregnant, date of last period _____

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):

- ☐ Asthma/Breathing problems
- ☐ Cancer
- ☐ Radiation/Chemotherapy
- ☐ Migraine/other severe head pain
- ☐ High Blood Pressure
- ☐ AIDS or HIV
- ☐ Kidney Stones
- ☐ Arthritis
- ☐ Seizures
- ☐ Phlebitis or blood clots
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Kidney infections
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Stomach Ulcer
- ☐ Tuberculosis
- ☐ Hepatitis

Other current or past medical problems:

_____

_____

_____

_____

_____

_____

_____

ALLERGIES:

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