

**Perth Neurosurgery - A/Prof Stephen Lewis**

**NEW PATIENT REGISTRATION FORM**

TITLE: Prof / Dr / Mr / Mrs / Ms / Miss (Please circle)

SURNAME: \_\_\_\_\_ GIVEN NAMES: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SUBURB: \_\_\_\_\_ STATE: \_\_\_\_\_ P/CODE: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE or FEMALE (Please circle)

OCCUPATION: \_\_\_\_\_ LEFT or RIGHT-HANDED (Please circle)

PHONE (H): \_\_\_\_\_ (W): \_\_\_\_\_ (M): \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

MEDICARE NO: \_\_\_\_\_ \*REF NO: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_\_

\*(number located to left of your name on Medicare card)

PENSION/HCC NO: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_\_

VETERANS AFFAIRS: Gold / Blue / White (Please circle) VX Number: \_\_\_\_\_

PRIVATE HEALTH FUND: \_\_\_\_\_ MEMBERSHIP NO: \_\_\_\_\_

DOES THIS COVER HOSPITAL ADMISSION: YES / NO (Please circle) LEVEL OF COVER: \_\_\_\_\_

IS YOUR APPOINTMENT RELATED TO WORKERS COMPENSATION: YES / NO (Please circle)

DATE OF ACCIDENT: \_\_\_\_\_ CLAIM NO: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PH: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

CASE MANAGER: \_\_\_\_\_ EMPLOYER'S INSURANCE COMPANY: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_ CLINIC: \_\_\_\_\_

USUAL FAMILY DOCTOR NAME: (if different from referring doctor) \_\_\_\_\_

GP ADDRESS: \_\_\_\_\_ SUBURB: \_\_\_\_\_ PHONE: \_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

**PLEASE INDICATE IF YOU TAKE THE FOLLOWING MEDICATIONS: (Please circle)**

- |   |          |
|---|----------|
| 1. Aspirin  | YES / NO |
| 2. Warfarin   | YES / NO |
| 3. Plavix   | YES / NO |
| 4. Clopidoril or other antiplatelet or blood thinning medications | YES / NO |
| 5. Fish Oil Supplements   | YES / NO |
| 6. Anti-Inflammatory Medication                                   | YES / NO |

**CURRENT MEDICATIONS YOU ARE TAKING:**

NAME	DOSE	FREQUENCY
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		

**PLEASE LIST ANY ALLEGIES YOU HAVE:**

\_\_\_\_\_

**PLEASE INDICATE IF YOU SUFFER / HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS: (Please circle)**

- |                        |                  |                 |                        |
|------------------------|------------------|-----------------|------------------------|
| 1. High Blood Pressure | 4. Heart Attack  | 7. Angina       | 10. Asthma             |
| 2. Open Heart Surgery  | 5. Cardiac Stent | 8. Stroke / TIA | 11. Diabetes           |
| 3. Chronic Infection   | 6. Migraines     | 9. DVT / PE     | 12. Notifiable Disease |

**PLEASE LIST ALL OTHER DOCTORS YOU ARE SEEING:**

NAME	SPECIALITY	LOCATION
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

**PLEASE LIST ANY PREVIOUS SURGERY:**

DATE	SURGERY	SURGEON	COMPLICATIONS
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

**DO ANY OF THE FOLLOWING DISEASES RUN IN YOUR FAMILY: (If yes, please circle)**

- |                        |   |
|------------------------|---|
| 1. Heart Disease       | 4. Cancer – type_____                       |
| 2. High Blood Pressure | 5. Brain or Spinal Cord Tumours – type_____ |
| 3. Diabetes            | 6. Other_____                               |

**DO YOU CURRENTLY SMOKE CIGARETTES?:**

No                      Yes                      If yes, how many cigarettes / day?\_\_\_\_\_

If you don't currently smoke, did you smoke in the past? No    Yes    When did you give up\_\_\_\_\_

**DO YOU DRINK ALCOHOL?:**

No                      Yes                      If yes, how many drinks / day\_\_\_\_\_

**DO YOU USE RECREATIONAL DRUGS?:**

No                      Yes

**ARE YOU AT RISK FOR AIDS? (Sexual orientation, drug abuse, previous blood transfusions)**

No                      Yes    If yes, please explain\_\_\_\_\_

**ARE YOU OR COULD YOU BE PREGNANT?:**

No                      Yes

**ON A SCALE OF 1 TO 10 WITH 10 BEING THE MOST EXTREME PAIN IMAGINABLE AND 1 BEING NO PAIN AT ALL  
WHAT IS YOUR CURRENT LEVEL OF PAIN EVERY DAY?:\_\_\_\_\_**