Patient Registration Form

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

Family Name: _____ First Name: _____ Middle Name: _____

Full Name Of Parent(s) If Patient Under 16: _____

Address: _____ Suburb: _____

Post Code: _____ Email: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Gender: _____ Age: _____ Date Of Birth: _____ Height: _____ Weight: _____

BMI:_____ Handedness: _____

Emergency Contact:

Next of Kin (Full Name) : _____ Relationship: _____

Mobile: _____ Work Phone: _____

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

Aged/Disability Pension: Yes No Membership Number: _____ Expiry: _____

Medicare Number: _____ Position on Card: _____ Expiry: _____

General Practitioners Name: _____

General Practitioners Address: _____

General Practitioners Telephone Number: _____

Workers Compensation and Compulsory Third Party

(Please note that if you are coming in under WC or CTP you will need to provide approval for your consultation on the day of or before your appointment otherwise you will be charged the full amount and once you receive approval you may claim back through insurance. Sorry for any inconvenience).

Employer Name (if applicable): _____ Date of Injury: _____

Employers Address: _____ Phone: _____

Solicitors Name & Address (if applicable) : _____

Claim Number: _____ Case Manager: _____

Telephone: _____ Fax: _____

Location of injury: _____ Date: _____ Type: _____

Chief Complaints: Please circle Yes or NO

Neck Pain: Yes No
Shoulder Pain: Yes No
Arm Pain: Yes No
Upper Back Pain: Yes No
Lower Back Pain: Yes No
Hip/Leg Pain: Yes No

Any other complaints: _____
Which area 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: _____
_____

Vital Signs/History of Present Illness

Date of Birth	Age			Height	Weight	Blood Pressure	Pulse
		o Male	o Right handed				
		o Female	o Left handed				

What is the main reason for your visit today?_____

_____

_____

Are you experiencing any of the following? Check all that apply

o balance problems
o difficulty swallowing
o disorientation
o dizziness
o enlargement of hands, feet or face
o excessive thirst
o excessive urination
o facial droop
o gait or walking problems
o hearing loss
o lethargy/sleepiness
o loss of coordination
o memory loss
o nausea/vomiting
o speech problems
o urinary incontinence
o weakness
o weight gain

These symptoms have been present for o 1-7 days o 8-14 days o 15-21 days o 1 month o 2 months o 3 months o 6 months o 9 months o 12 months o greater than 12 months

These symptoms started on (give specific date, if known)_____

How would you describe your symptoms since they began? o better o worse o no change

How did this problem begin? Please explain: _____

_____

_____

If you answered "yes" to speech problems, please describe the problem you are having:_____

_____

_____

Describe your daily level of function o independent/fully active o independent/limited to light duty work or light activity o independent/unable to do any work o dependent on others for some of my activities o completely dependent on others

Are you having seizures? o yes o no **If yes, please complete the Seizure Questionnaire below:**

Seizure Questionnaire - complete only if you are having seizures

When was your first seizure?_____ When was your last seizure?_____

How frequent are your seizures?_____

Who has treated you for your seizures?_____

Describe your seizures_____

Have you been given a seizure diagnosis? o no o grand mal o petit mal o simple partial o complex partial

Seizure Questionnaire, continued

What medications are you currently using for seizures?

Drug Name	Strength	Directions

What medications have you used for seizures in the past?

Drug Name	Strength	Directions

Are you having headaches or facial pain? o yes o no
If yes, please complete the Headache or Facial Pain Questionnaire below:

Headache or Facial Pain Questionnaire - complete only if you are having headaches or facial pain

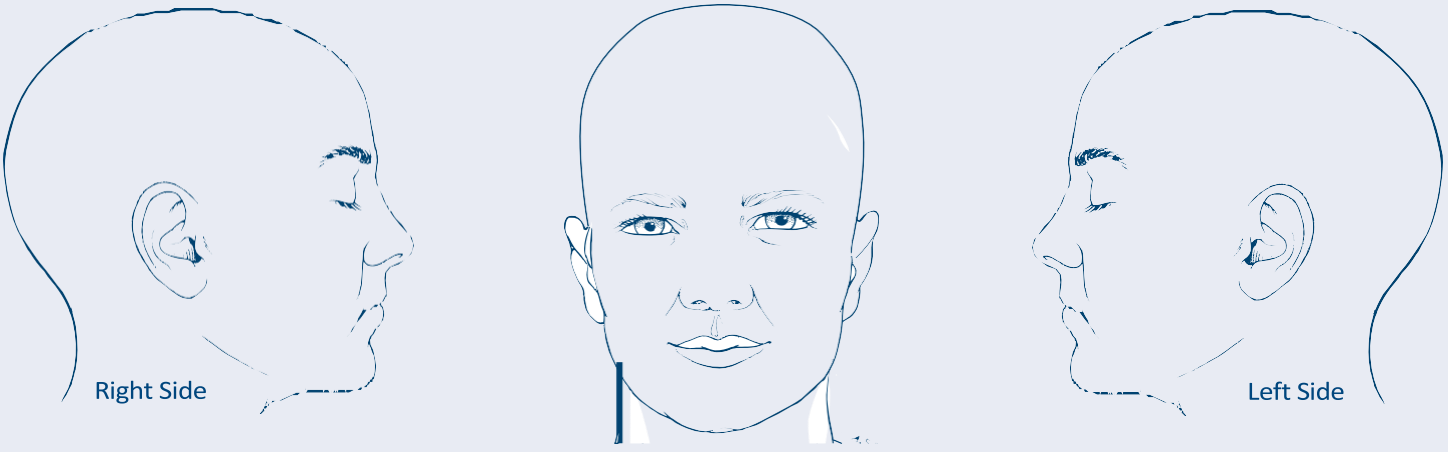
Severity of pain (circle one): 1 2 3 4 5 6 7 8 9 10 (1 = least pain 10 = worst pain)

Frequency o constant o intermittent - how often_____

Timing - pain occurs o in the morning o in the evening o after work o wake you from sleep o other_____

Location of pain (mark all that apply) o forehead o behind the right eye o behind the left eye
o behind both eyes o top of the head o back of the head o left side of face o right side of face o neck

Please mark (X) where your pain is located:



Headache or Facial Pain Questionnaire, continued

How long have you had this pain?
o 1-7 days o 8-14 days o 15-21 days_____month(s)____year(s)

Associated symptoms (check all that apply) o nausea o auras o weakness o numbness o visual symptoms

o other_____

Quality of the pain? o sharp o dull o throbbing o electrical o other_____

Do you have a family history of headaches or facial pain? o yes o no

What treatments have you had for your pain?_____

_____

_____

Do you have a pain diagnosis? o no o cluster o tension o migraine o trigeminal neuralgia/tic douloureux
o other_____

What makes your pain worse? Do certain positions?_____

_____

What makes your pain better? Do certain positions?_____

_____

Does Valsalva (straining or bearing down) make your pain worse? o yes o no

Are you having visual symptoms? o yes o no **If yes, please complete the Visual Symptoms Questionnaire below:**

Visual Symptoms Questionnaire - complete only if you are having visual symptoms

Is this problem o decreased vision o difficulty reading o loss of peripheral vision o double vision

o other _____

Does it affect the o right eye o left eye o both eyes

Are the symptoms o constant o intermittent

How long have you had these visual symptoms?_____

Have you seen an ophthalmologist? o yes o no

If yes, who?_____**When?**_____

Previous Diagnostic Tests

Provide as much information as possible regarding any of the following tests you have had for this illness or injury.

	Mo./Yr.	Where		Mo./Yr.	Where
MRA/MRV	__/__	_____	Vision test	__/__	_____
MRI scan	__/__	_____	Hearing test	__/__	_____
CT scan	__/__	_____	Angiogram	__/__	_____
PET scan	__/__	_____	Doppler	__/__	_____
Labs	__/__	_____	Other	__/__	_____

Previous Treatment

Please check the following treatments you have had for your current medical condition and provide the information requested.

	Date(s) performed	Where performed	Who performed
o surgery			
o biopsy			
o shunt			

Radiation therapy

o external/focused beam	
o whole brain	
o radiosurgery	

	Therapy/drug name(s)	Date(s)
o chemotherapy	o Temodar o Avastin o BCNU o thalidomide o others_____	
o clinical trials		
o alternative therapies		

Medication History

List all current medications, including "over the counter" medications, prescription medications, and herbal supplements.

Name	Dose	Directions	Name	Dose	Directions

Are you taking blood thinners? o yes o no If yes, which? o aspirin o Coumadin o Plavix o other_____

Allergies

Are you allergic to any medications? o yes o no **If yes, which medicine?** _____

What happens? _____

Are you allergic to o iodine o contrast dye o shellfish o latex o tape o metals/jewelry

What happens? _____

Do you have any other allergies? o yes o no **If yes, what are you allergic to?** _____

What happens? _____

Have you ever had an allergic reaction to a blood transfusion? o yes o no

Past Surgical/Medical History

Have you ever had any other operations/surgery? o yes o no

If yes, when? _____ Describe the surgery _____

_____

Have you been diagnosed with any of the following? (check all that apply)

o anemia
o angina/chest pain
o arrhythmia/irregular heartbeat
o asthma
o congestive heart failure
o coronary artery disease
o diabetes
o elevated cholesterol
o elevated triglycerides
o heart attack
o heart disease
o high blood pressure
o kidney disease
o lung disease/COPD/emphysema
o malignancy/cancer
o malignant hyperthermia
o mental health disorder/ depression/anxiety
o osteoporosis
o peripheral vascular disease
o phlebitis/bleeding disorder
o sleep apnea
o staph infection (e.g. MRSA)
o stroke
o thyroid disease

If yes, explain _____

Do you have any other medical conditions? o yes o no If yes, explain _____

Have you ever been treated for blood clots or excessive bleeding? o yes o no

Is there any reason you cannot receive blood or blood products? o yes o no

If yes, explain _____

Have you ever had angioplasty? o yes o no

Do you have any stents placed? o yes o no If yes, when? _____

Do you have any other implant devices (i.e., pacemaker, morphine pump, spinal cord stimulator)? o yes o no

Explain _____

Have you had a flu shot? o yes o no If yes, when? _____
Have you had a pneumonia vaccine? o yes o no If yes, when? _____

Social History

Are you a veteran? o yes o no

Do you live alone? o yes o no

Indicate your marital status o single o married o widowed o divorced o partner

If married, does your spouse work? o yes o no

Are you pregnant? o yes o no **If yes, when is your due date?**_____

Do you have any children? o yes o no

If yes, indicate sex, age(s) and whether they live at home_____

_____

Do you currently use or have you ever used any tobacco products? o in the past, but quit o yes o no

If yes, specify o cigarettes o chewing tobacco o snuff tobacco o cigars o pipe

How much/day_____For how many years_____When did you quit_____

Do you currently drink alcohol? o yes o no o recovering alcoholic

If yes, specify o beer o wine o liquor

How many drinks/week_____For how many years_____

Do you currently use or have you ever used any recreational drugs? o in the past, but quit o yes o no

If yes, specify o marijuana o cocaine o speed o hallucinogens o narcotics o other

How much/day_____When did you quit_____

Have you ever received treatment for drug and/or alcohol problems? o yes o no

If yes, specify when and where_____

Have you ever been exposed to radiation? o yes o no **Chemicals?** o yes o no

If yes, describe_____

Work History

Highest grade level achieved in school o grade school o high school o Bachelor's o Masters

Are you currently employed? o yes o no o retired

Employer_____**Length of employment** _____

Job title_____**How long have you done this job?**_____

If employed, are you currently working with these symptoms? o yes o no

Does your job require you to:

o lift____pounds	o bend
o sit	o drive a truck or forklift
o use a computer	o reach over head
o lift over head	o stand

If not currently working, did a physician place you off work? o yes o no

If yes, please list physician's name _____

If not currently working, when did you stop working? _____

Family History

Has a <u>parent, sibling or offspring</u> had any of the following conditions? Please check all that apply and indicate the relationship of the person who has/had the condition.

Condition	Relationship (mother, father, sister, brother, son, daughter)
o Alzheimer's/memory loss	
o aneurysm	
o blood clots/clotting disorders	
o depression/mental problems	
o diabetes	
o heart problems	
o high blood pressure	
o kidney disease	
o life threatening complications to anesthesia	
o lung problems	
o malignant hyperthermia	
o multiple sclerosis	
o Parkinson's disease	
o stroke	
o brain tumor	
o breast tumor	
o cervical tumor	
o colon cancer	
o kidney cancer	
o leukemia	
o liver cancer	
o lung cancer	
o lymphoma	
o ovarian cancer	
o pancreatic cancer	
o prostate cancer	
o skin cancer	
o spine tumor	
o thyroid cancer	
o cancer-other _____	
o other problems _____	

Review of Systems

Do you currently have any of the following problems (please answer "Yes" or "No" to every item; do not skip any):

GENERAL
fever o yes o no
chills o yes o no
sweats o yes o no
anorexia o yes o no
fatigue o yes o no
malaise (body weakness) o yes o no
weight loss o yes o no

EYES
blurring o yes o no
diplopia (double vision) o yes o no
eye irritation o yes o no
eye discharge o yes o no
vision loss o yes o no
eye pain o yes o no
photophobia (sensitivity to light) o yes o no

EAR/NOSE/THROAT
earache o yes o no
ear discharge o yes o no
tinnitus (ringing in ears) o yes o no
decreased hearing o yes o no
nasal congestion o yes o no
nosebleeds o yes o no
sore throat o yes o no
hoarseness o yes o no
dysphagia (difficulty swallowing) o yes o no

HEART
chest pains o yes o no
palpitations o yes o no
syncope (passing out) o yes o no
difficulty breathing on exertion o yes o no
difficulty breathing when sitting/standing o yes o no
peripheral edema o yes o no

RESPIRATORY
cough o yes o no
difficulty breathing o yes o no
excessive sputum o yes o no
hemoptysis (spitting up blood) o yes o no
wheezing o yes o no

GASTROINTESTINAL
nausea o yes o no
vomiting o yes o no
diarrhea o yes o no
constipation o yes o no
change in bowel habits o yes o no
abdominal pain o yes o no
melena (black or tarry stool) o yes o no
bloody stool o yes o no
jaundice o yes o no

PSYCHIATRIC
depression o yes o no
anxiety o yes o no
memory loss o yes o no
hallucinations o yes o no
other mental health problems o yes o no

GENITOURINARY
incontinence o yes o no
difficulty urinating o yes o no
urinating blood o yes o no
urinary frequency o yes o no
pelvic pain o yes o no

MUSCULOSKELETAL
back pain o yes o no
neck pain o yes o no
joint pain o yes o no
joint swelling o yes o no
muscle cramps o yes o no
muscle weakness o yes o no
stiffness o yes o no
arthritis o yes o no

SKIN
rash o yes o no
itching o yes o no
dryness o yes o no
suspicious lesions o yes o no

NEUROLOGIC
intermittent paralysis o yes o no
weakness o yes o no
paresthesia (prickly/tingling sensation) o yes o no
seizures o yes o no
syncope (passing out) o yes o no
tremors o yes o no
vertigo (dizziness) o yes o no
numbness o yes o no
imbalance o yes o no
incoordination o yes o no
headache o yes o no
visual changes o yes o no
tinnitus (ringing in ears) o yes o no

ENDOCRINE
cold intolerance o yes o no
heat intolerance o yes o no
polydipsia (excessive thirst) o yes o no
polyphagia (excessive eating) o yes o no
polyuria (excessive urination) o yes o no
weight change o yes o no

HEMATIC/LYMPHATIC
abnormal bruising o yes o no
abnormal bleeding o yes o no
enlarged lymph nodes o yes o no

ALLERGY
urticaria (itching) o yes o no
hay fever o yes o no

IMMUNOLOGIC
persistent infections o yes o no
HIV exposure o yes o no

Patient signature_____
Date

_____
Date_

_____