



Dr R E Pope

Beneficence and Nonmaleficence
Neurosurgeon and Spine Surgeon

Title

Surname **Given Names**

Address
..... **Postcode**

Date of Birth

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:

Information will be held in the strictest of confidence in accordance with the Health Records and Information Privacy Act 2002 (NSW)

Dr Raoul Pope MBChB (Hons, Otago) FRACS Specialist Neurosurgeon and Spine Surgeon

The Poche Centre , Suite 8, Level 3, 40 Rocklands Rd, North Sydney NSW 2060
The Sydney Spine Institute, Suite 107/3 Railway Parade, Burwood, NSW 2134
p: 02 9911 7280 | f: 02 9954 9307 | e: info@spinesurgeon.com.au | w: www.spinesurgeon.com.au

Provider No. 2300 28DX | ABN: 55 002 611 382

Your main problem

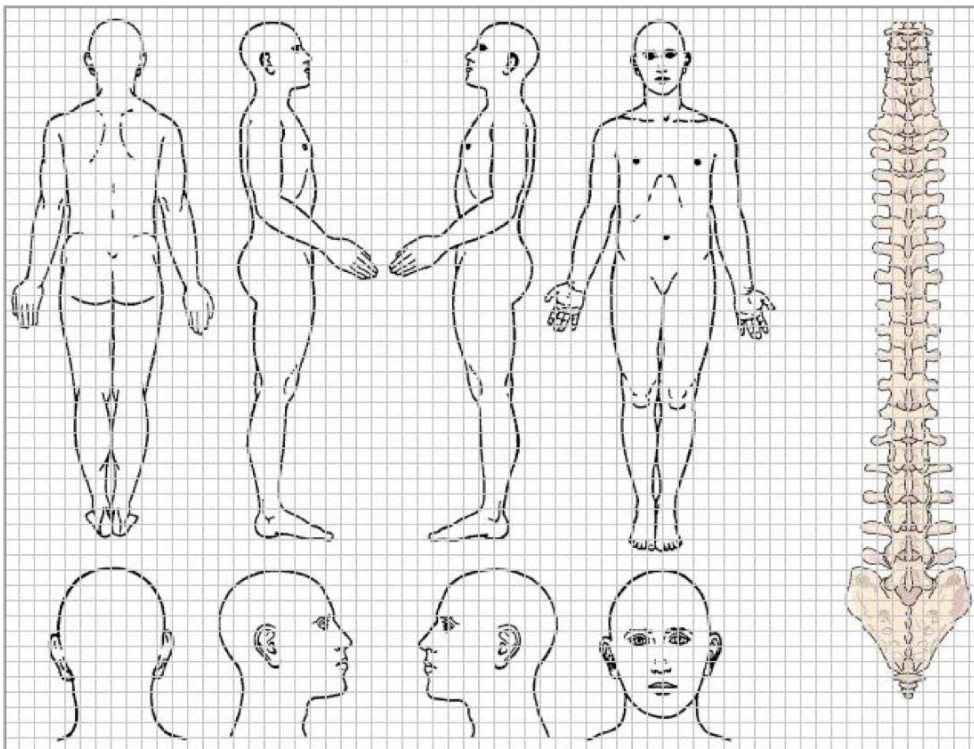
Briefly describe your problem....

.....

.....

.....

Highlight on the pictures where your problem is...



Indicate current level of pain on the following scale (circle):

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

General health information.

Do you take **blood thinning** medications? YES / NO (eg: aspirin, warfarin, clopedigrel)

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:
.....
.....
.....

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/AIDS	Hepatitis B or C	Long standing infections
Cancer of any type	Radiotherapy	Chemotherapy
Depression	Migraine	Seizures
Gastric ulcers	Reflux	Constipation

Do you **smoke**? YES / NO How much per day:

Do you **drink alcohol**? YES / NO How much per day:

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*