ADVANCED SPINE INSTITUTE for NECK and BACK surgery

PATIENT HISTORY HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____ /_____ /_____

What is your current complaint? _____

_____

How did you get injured or hurt? _____

_____

Date of Injury or Onset of Symptoms: _____ /_____ /_____

Were you injured at work? ☐ Yes ☐ No

Is there any possibility that you are pregnant? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No
If yes, list the medication and your reaction to the medication: _____

_____

Please list your current medications including over the counter and herbal medications.
Please list medication name, dosage, and frequency for each.

_____

_____

_____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Telephone Number: (_____) _____

Name of your Primary Care Physician: _____

Telephone Number: (_____) _____

Please name all other Doctors that care for you:

1. _____ Telephone Number: (_____) _____

2. _____ Telephone Number: (_____) _____

(please continue on the back page)

TREATMENT HISTORY

Medical Test Already Performed: ☐ X-RAYS ☐ MRI ☐ CAT SCAN ☐ BONE SCAN

☐ MYELOGRAM ☐ EMG/NCS OTHER: _____

Back: Have you had back problems before this? ☐ Yes ☐ No

Neck: Have you had neck problems before this? ☐ Yes ☐ No

If so, have you seen any other doctors for this problem? (List): _____

_____

What types of treatment have you received for your back or neck? Did it give you any relief?
(Check the appropriate column)

	Excellent	Moderate	None	Not Tried		Excellent	Moderate	None	Not Tried
Bed rest					Chiropractic				
Traction					Ice				
Surgery					Pain Medication				
Hypnosis					Muscle Relaxants				
Acupuncture					Anti - inflammatory				
Nerve Block					Corticosteroid Injection				
TENS Unit					Cervical Facet Injection				
Physical Therapy					Lumbar Facet Injection				
Exercise					Epidural Injection				
Psychotherapy					Back Brace				

What relieves or worsens your pain? *(Check the appropriate column)*

	Relieves	Worsens	Unchanged		Relieves	Worsens	Unchanged
Alcohol				Morning			
After Exercise				Night			
During Exercise				Physical Therapy			
Bending Backwards				Intercourse			
Bending Forwards				Sitting			
Cold Weather				Sneezing			
Damp Weather				Standing			
Coughing				Stress			
Fatigue				Touching Skin			
Heat				Twisting			
Ice				Walking			
Injections				Work			
Lying Down				Nothing			
Medications							

(please continue on the next page)

PAST MEDICAL HISTORY

Do you have a history of any of the following?

Epilepsy	Y	Tuberculosis	Y
Head Injury	Y	Asthma	Y
Meningitis	Y	Emphysema	Y
Stroke	Y	Pneumonia	Y
Migraines	Y	Bronchitis	Y
Vertigo	Y	COPD	Y
Diabetes	Y	Prostate Problems	Y
Liver Disease	Y	Kidney Disorder	Y
Hepatitis	Y	Kidney Stone	Y
		Kidney Failure	Y
Thyroid Disorder	Y		
		Arthritis	Y
Depression	Y	Gout	Y
Sleeping Disorder	Y	Autoimmune Disease	Y
Sleep Apnea	Y		
		Fibromyalgia	Y
Glaucoma	Y	Multiple Sclerosis	Y
Vision Changes	Y	HIV	Y
Loss of Hearing	Y		
Sinus Problems	Y	Upper GI Bleed	Y
		Ulcerative Colitis	Y
Coronary Artery Disease	Y	Acid Reflux	Y
Prior Heart Attack	Y	Stomach Ulcer	Y
Heart Murmur	Y	Irritable Bowel Syndrome	Y
Heart Valve Replacement	Y		
High Cholesterol	Y	<u>Hematological</u>	
High Blood Pressure	Y	Anemia	Y
Raynaud's disease	Y	Sickle Cell	Y
Aneurysm	Y	Blood Clots	Y
Stroke	Y	Blood Disorder	Y
History of Cancer in yourself.	Y	<u>Psychological</u>	
		Depression	Y
		Alcohol Abuse	Y
		Substance Abuse	Y

Type(s), and Date(s): _____

_____

_____

SURGICAL HISTORY

Have you ever had an operation? If yes, list operations and year they were performed.

_____

_____

_____

_____

_____

(please continue on the back page)

SOCIAL HISTORY

What is your occupation? _____

Specific Duties: _____

_____

Are you working? ☐ Yes ☐ No

If no, what is the last date you worked? _____ /_____ /_____

If yes, are you working with restrictions? ☐ Yes ☐ No

Does your employer have light duty available? ☐ Yes ☐ No ☐ Unknown

Have you ever been injured on the job before? ☐ Yes ☐ No

If so, for what reason? _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Use of alcohol: ☐ Never ☐ Occasionally ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously, but quit ☐ Currently packs per day _____

Chewing tobacco: ☐ Never ☐ Previously, but quit ☐ Currently Amount per day _____

Vaper Tobacco: ☐ Never ☐ Previously, but quit ☐ Currently Amount per day _____

Use of illegal/street drugs: ☐ Previously, but quit ☐ Type/Frequency _____

Are you on any special diet? _____

Hobbies: _____

Sports: _____

Do you CURRENTLY exercise? ☐ Yes ☐ No
If so, what type of exercise and how many times per week? _____

_____

FAMILY HISTORY

Who, if anyone, in your family has had any of the following:

Diabetes _____ High Blood Pressure _____

Heart Disease _____ Cancer _____

Stroke _____ type _____

(please continue on the next page)

REVIEW OF SYSTEMS

Do you now have any of the following?

Constitutional	
Fever (unexplained)	Y
Chills	Y
Night sweats	Y
Weight loss (unexplained)	Y

Cardiovascular/Pulmonary	
Chest Pain	Y
Shortness of Breath while resting	Y
Shortness of Breath with exertion	Y
Abnormal Heart Rhythm	Y
High Blood Pressure	Y
Lower Extremity Swelling	Y
Cramping in Calves When Walking	Y
Wounds or Ulcers on Feet	Y

Endocrine	
Excessive Sweating	Y
Excessive Thirst	Y

Gastrointestinal	
Difficulty Swallowing	Y
Heartburn	Y
Nausea	Y
Vomiting	Y
Abdominal Pain	Y
Diarrhea	Y
Other Gastrointestinal problems	Y

Genitourinary	
Bladder problems	Y
Frequent Urinary Infection	Y
Blood in Urine	Y
Urgency with Urination	Y
Frequent Urination	Y
Incomplete Emptying	Y

Hematological	
Lymph Nodes Enlarged	Y
Easy Bruising Tendency	Y

Neurological	
Dizziness	Y
Balance Problems	Y
Weakness	Y
Numbness/Tingling	Y
Other Neurological problems	Y

Psychological	
Confusion	Y
Anxiety	Y
Memory Problems	Y
Other Psychological problems	Y

Skin	
Breast lump / discharge	Y
Sores that will not heal	Y
Rashes	Y

Physician Initials: _____

(please continue on the back page)

PAIN INTENSITY RATING

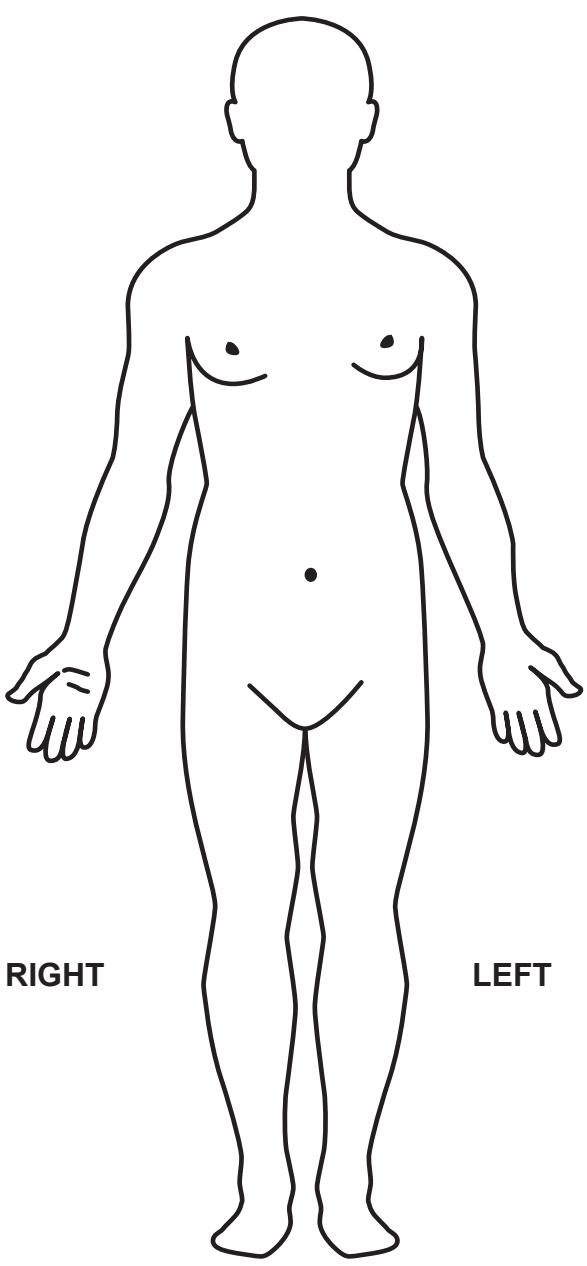
On the line below, CIRCLE your AVERAGE PAIN over the last week.

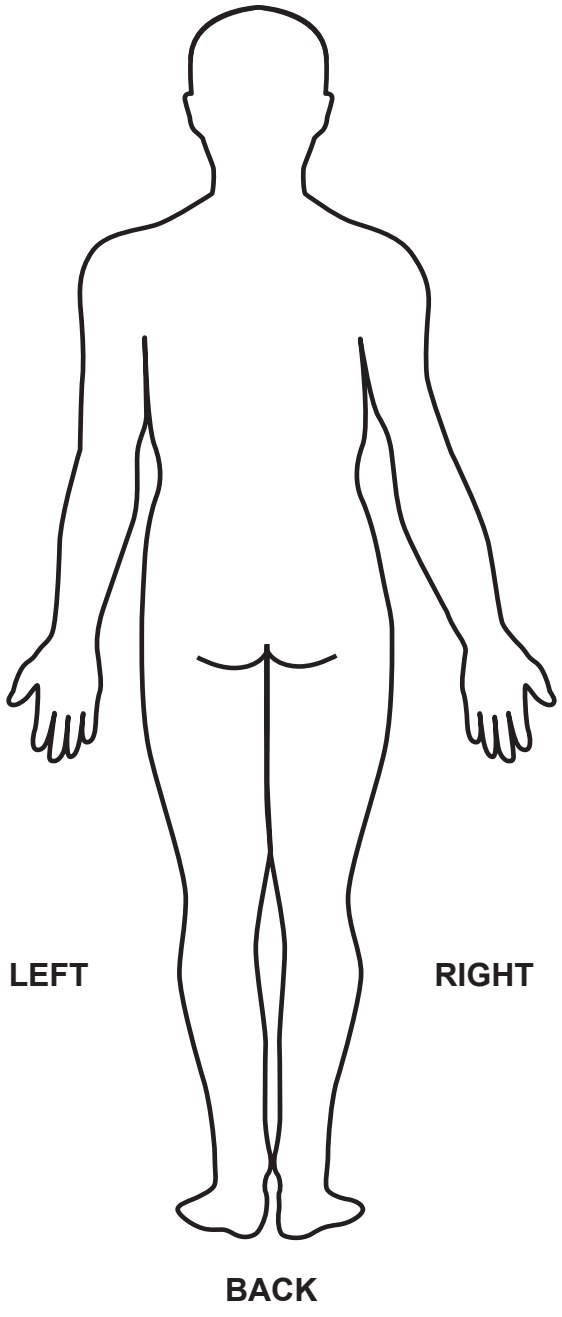
No Pain										Worst Possible
0%	10	20	30	40	50	60	70	80	90	100%

PAIN DRAWING

WHERE IS YOUR PAIN NOW? Use appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area of pain if it radiates or spreads to other areas.

BURNING X	NUMBNESS O	PINS and NEEDLES =	STABBING /	ACHE △





Physician Initials: _____ Date: _____ /_____ /_____