PLEASE BRING COMPLETED PACKET TO APPOINTMENT ALONG WITH YOUR FILMS

Advanced Spine Associates, P.A.

NEW PATIENT
MEDICAL HISTORY QUESTIONNAIRE

Exam Date_____
M.D. _____
Exam Location _____

Name _____
Address _____
City _____ State _____ Zip _____
Age _____ Date of Birth _____ Sex ___M ___F
Phone (Home) _____ (Work)_____

___ Worker's Comp. ___ Motor Vehicle Accident ___ Personal Injury ___ Other

Date of Injury___/___/___ State _____

Referral Source: _____ Primary Care Physician: _____

Attorney Name: _____Phone #: _____

CHIEF COMPLAINT

Pain Location:

___Neck/Upper Back	___Mid Scapular	___R/L/Both Groin
___R/L/Both Shoulder	___Mid/Lower Back	___R/L/Both Buttock/Leg
___R/L/Both Arm	___R/L/Both Hip	

Which pain is most severe, or are all areas of pain equal in severity? _____

HISTORY OF PRESENT ILLNESS

Present Complaints:

Date of Onset _____ Date of Injury _____

Description/details of onset/injury:

_____
_____
_____

Is your current pain: ____More severe _____essentially unchanged _____improved since the date of onset/injury?

Specific location/description of pain:

_____
_____
_____
_____
_____

Treatment for current problem: In chronological order, past to present, including approximate dates, doctors, names and locations, X-rays, CT, MRI, Myelogram, and details of treatment, including what did and did not help, physical therapy, massage therapy, chiropractic care, acupuncture and medications (i.e. pain medications, anti-inflammatories, muscle relaxant medications), procedures (i.e. epidural steroid injections, surgery, etc.):

_____
_____
_____
_____
_____
_____
_____

Pain Rating on a scale from 1-10 (10 being the worst):

Neck: _____
Back: _____
Leg or Arm: _____

Aggravating factors/what makes the pain worse?

_____
_____

Alleviating factors/what makes the pain better?

_____
_____

SLEEP

1. Do you have difficulty falling to sleep due to the pain? ___ Yes ___ No
   If "Yes", do medications help? ___ Yes ___ No

2. Do you wake frequently due to pain? ___ Yes ___ No
   If "Yes", do you:
   _____ Get up to walk/take medications before lying down again, or
   _____ Reposition yourself to get back to sleep?
   _____ Both

PAST SPINE HISTORY

In chronological order, past to present, include dates and description of pain from previous Worker's Compensation or Motor Vehicle Accident injuries to the spine, and details of treatment including spine surgeries and whether or not you had more severe pain, essentially no change, improvement or complete resolution of the pain following treatment or surgery. If improvement or complete resolution of pain was noted, for how long?

_____

_____

_____

_____

_____

_____

X-RAYS

Date Type of X-ray/scan Location/Physician

_____ ___Available___N/A

_____ ___Available___N/A

_____ ___Available___N/A

_____ ___Available___N/A

Records related to prior treatment? ___Available___N/A

WORK STATUS

1. Are you currently employed PT / FT / Unemployed / Retired (please circle one)
   If employed, how many hours per day/week?_____
   Go to #2 below.

   If unemployed, for how long?_____

   What type of work did you do prior to this?_____

   If retired, for how long?_____

   What type of work did you do prior to this treatment?_____

   If employed, please complete the following:

2. What is your employer's name and what city are they located?

   Name:_____

   City:_____

3. What is your occupation/job title?_____

4. How long have you been employed there?_____

5. What does your job involve? (please check all that apply)

_____Sitting _____Kneeling _____Squatting _____Bending
_____Standing _____Pushing _____Twisting _____Walking
_____Climbing (stairs, ladders, step stool) _____Lifting up to ___ pounds frequently/occasionally

6. Have you missed any work due to the pain? ___ Yes ___ No
If "Yes", please indicate time off of work

Off since___ Date of injury ___1-2 days intermittently ___ Since (date)_____

7. Are you currently working light-duty status with work restrictions and/or ad reduced hours? ___ Yes ___ No

If "Yes", please list work restrictions/hours:_____
_____ pounds lifting restriction.

PAST MEDICAL HISTORY

Allergies

Do you have any allergies to medications or anesthesia? ___ Yes ___ No

If "Yes", please list them and reactions to each:

_____

_____

Environmental allergies? ___ Yes ___ No

If "Yes", please list them and reactions to each:

_____

_____

Medications

Are you currently taking any medications related or not related to your pain? ___ Yes ___ No

If "Yes", please list them:

Medications Dosage How Often Reason

_____

_____

Illnesses (Please check all that apply and list others)

___Diabetes	___Asthma	___Radiation/Chemotherapy
___Hypertension	___Emphysema	___Hypothyroidism
___Heart Problems	___Chemical Dependency	___Hyperthyroidism
___Cancer (type)_____	___ Epilepsy	___Gastrointestinal (ulcers,
___Other_____		heartburn, etc.)

Surgeries

Have you ever had any surgeries performed? ___ Yes ___ No
If "Yes", please indicate what type of surgery and approximate date:

FAMILY MEDICAL HISTORY

The following questions pertain to your immediate family members only including mother, father, brothers, sisters, sons, daughters, and grandparents. For "Yes" answers, please indicate which relative.

1. Is there any cancer in your immediate family? ___ Yes ___ No

2. Is there any diabetes in your immediate family? ___ Yes ___ No

3. Is there any heart disease in your immediate family? ___ Yes ___ No

4. Other (including family members with spine problems) ___ Yes ___ No

SOCIAL HISTORY

1. Marital Status:___ Single ___ Married ___ Divorced ___ Separated ___Widowed

2. Do you have any children? ___ Yes ___ No
   If "Yes", how many children_____/Adult_____

3. Are you a smoker? ___ Yes ___ No
   If "Yes", how many packs per day?_____
   How long have you been a smoker?_____Years _____Months

   If "No", have you ever been a smoker? ___ Yes ___ No
   If "Yes", how long ago did you quit smoking?_____Years _____Months

4. Do you drink alcohol? ___ Yes ___ No
   If "Yes", how often? ___ Daily ___Occasionally ___ Rarely

5. Do you drink coffee? ___ Yes ___ No
   If "Yes", how many cups per day?_____

REVIEW OF SYSTEMS

Please answer the following questions be checking "Yes" or "No". Please explain "Yes" answers in the space provided.

1. Do you experience headaches? ___ Yes ___ No
   How often?_____

2. Do you have any upper respiratory/breathing problems? ___ Yes ___ No

3. Do you have any eye problems? ___ Yes ___ No

4. Do you have any ears, nose, mouth or throat problems? ___ Yes ___ No

5. Do you have any blood pressure problems? ___ Yes ___ No

6. Do you have any heart problems? ___ Yes ___ No

7. Have you had any seizures, circulatory problems or strokes?___ Yes ___ No

8. Do you have any urinary or kidney problems? ___ Yes ___ No
(Frequency / Urgency / Incontinence)
If "Yes", how long have these symptoms been present?_____Years _____Months

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9. Do you have any bowel problems? ___ Yes ___ No
(Constipation / Diarrhea)

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10. Do you have any joint problems, pain or swelling? ___ Yes ___ No

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11. Do you have any blood disorders or
diseases of the lymphatic system? ___ Yes ___ No
(Leukemia / Lymphoma)

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12. Have you had any weight loss recently? ___ Yes ___ No
(Attempted / Unattempted)_____pounds In what amount of time_____
Dates / How long ago?_____

13. Do you experience night sweats? ___ Yes ___ No
(Intermittently / Frequently)
(Short-term / Recent / Long-term)

14. Have you ever been hospitalized? ___ Yes ___ No
For surgeries only? ___ Yes ___ No
If "No", when / how long ago and for what reason?
