Spine Surgery

Department of Orthopaedic Surgery

MR # (Office Use Only): ____________________

Name: ______________________________

Date of Birth:__________Age: _________

Occupation: ___________________________

Phone # (____)_______________________

Email address: _________________________

Height ________ Weight __________

Who is your regular / general physician?

____

Who referred you to our practice?

____

Would you like a letter sent to these physicians regarding your visit? ☐ Yes ☐ No

SPINAL HISTORY (Please tell us about your neck or back problems)

1. Do you have back / neck (circle one) pain? ☐ Yes ☐ No

Pain started on: ____/____/_______ (Date of injury, accident or onset of pain)

How did you injure you back / neck? ____

____

Type of pain: ☐ Ache ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click or Pop

Pain Worsened By: ☐ Standing ☐ Walking ☐ Sitting ☐ Lying ☐ Driving ☐ Working ☐ Stairs ☐ Rest ☐ Sleeping

Did you have any previous spine pain, problems or injuries? ☐ Yes ☐ No

If yes, please explain: ____

2. Do you have leg / arm (circle one) pain? ☐Yes ☐ No

Where does your leg/arm pain spread?

☐ Starts in my back/neck and goes down my leg/arm

☐ Starts in my leg/arm and goes up to my back/neck

3. How much of your problem is back/neck pain compared to leg/arm pain? (check one of the following boxes)

☐ Back 0%, Leg 100% ☐ Back 25%, Leg 75% ☐ Back 50%, Leg 50% ☐ Back 75%, Leg 25% ☐ Back 100%, Leg 0%

☐ Neck 0%, Arm 100% ☐ Neck 25%, Arm 75% ☐ Neck 50%, Arm 50% ☐ Neck 75%, Arm 25% ☐ Neck 100%, Arm 0%

4. Do you have weakness in your arms, hands, legs or feet? ☐Yes ☐No

5. Do you have numbness or pins and needles in your arms, hands, legs or feet? ☐Yes ☐No

6. Do you have a problem with clumsiness, balance or tripping frequently? ☐Yes ☐No

7. Do you have any bowel or bladder incontinence? ☐Yes ☐No

8. Treatments Attempted: ☐ None ☐ Pain Medications ☐ Anti-Inflammatory ☐ Ice ☐ Traction ☐ Chiropractor

☐ Injections – If so, what type and when? ____

☐ Physical Therapy – If so, when and for how long? ____

9. Have you had any tests done on your back or neck (Check all that apply, Provide dates of test)?

☐ MRI ___________________ ☐ CT Scan _______________ ☐ Other ______________________

10. Have you ever had back or neck surgery? ☐ Yes ☐ No

If yes, where (include Date, Surgeon, Hospital, City, and State)? ____

____

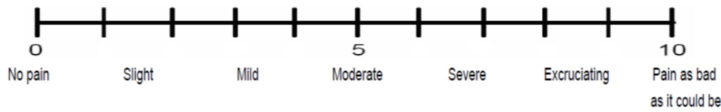
Why did you have the surgery? ____

Did the surgery relieve the pain? ☐ Yes ☐ No ☐ Partial

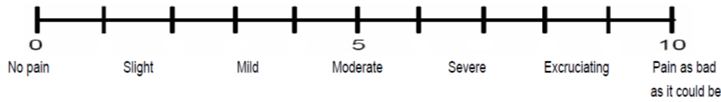
Has the same pain returned? ☐ Yes ☐ No ☐ My Pain is different now

(Please turn over and complete second page)

My back/neck pain is: (please mark with "X")



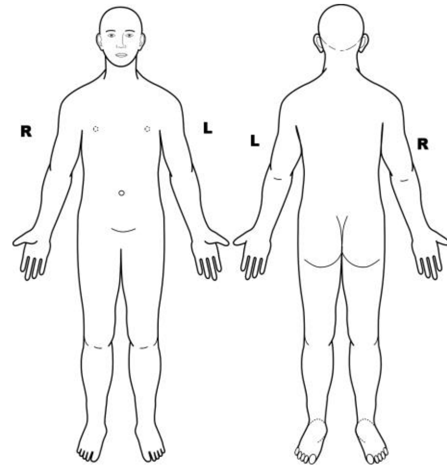
My leg/arm pain is: (please mark with "X")



Please indicate type and distribution of your pain on the figures below

Please use the following key to shade in the distribution of pain on figures

NUMBNESS	PINS & NEEDLES	ACHE	PAIN
---------------	OOOO	XXXX	////



MEDICAL HISTORY

Please list any health problems that you are currently diagnosed with:

□ Heart Disease
□ Cancer
□ Stomach Ulcers
□Asthma
□ High Blood Pressure
□ Diabetes
□ Kidney Disease
□ DVT (Blood Clots)
□ Pulmonary Embolism
□ Lung Disease
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Gout
□ Chronic Headache(s)
□ Liver Disease
□ Seizures
□ Stroke
□ Thyroid Problems
□ Depression
□ Infections (Please explain):_______________
____
□Other Conditions (Please explain)_______________
____

Please list any other prior surgeries (include type of surgery and year):
____
____

Please list your medications and dosages: ____
____

Please list any known drug allergies:
□ **NONE**

□ Penicillin
□ Sulfa Drugs
□ Iodine
□ Diagnostic Dyes
□ Morphine
□ Codeine
□ Aspirin
□ Ibuprophen
□ Acetaminophen
□ Latex
□ Metals (specify)
____
□ Other:_________
____
____

Do you smoke? ☐ Yes ☐ No ______Packs/Day ☐ Quit: ______ Months Ago ______ Years ago

Do you drink alcohol? ☐ Yes ☐ No If yes, ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

Is there a history of back or neck problems in your family? ☐ Yes ☐ No

Review of Systems: (Please circle and/or write in)
General (weight loss/gain, night sweats, fatigue, fever, chills): _______________
Head (headaches, dizziness): _______________
Eyes (change in vision, pain, infections, glasses, contacts, vision loss): _______________
Ears (change in hearing, pain, infections, hearing loss): _______________
Nose, Throat, Mouth (sinus trouble, nosebleed, toothaches, infection, sore throat):_______________
Lungs (sleep apnea, cough, shortness of breath pneumonia, tuberculosis, COPD, emphysema): _______________
Heart (chest pain, irregular heart beat, swollen ankles): _______________
Gastrointestinal (nausea, vomiting, diarrhea, constipation, incontinence, blood in stools, hepatitis):_______________
Urinary (blood in urine, frequent urination, incontinence, kidney stones, bladder or kidney infections): _______________
Skin (rash, bruises, change in moles, infections, cancer, eczema): _______________
Musculoskeletal (arthritis, joint pain, varicose veins): _______________
Immunological (rheumatoid arthritis, lupus, ankylosing spondylitis): _______________
Emotional (depression, anxiety, bipolar disorder, stress): _______________
Anything else that may be important for me to know: _______________

Patient Signature: _______________________ Date: _______________