Orthopedic Sports Medicine & Spine Care Institute

PATIENT HISTORY HEALTH QUESTIONNAIRE

Name: _____ — Today's Date:___/___/ ____

Email: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Ht: _ _ _ _ _wt:_ _ _ _ _ _

Date of Birth: _/_/_ Age:_ Sex: Male Female

Is your problem related to a work injury or accident?_____Yes_____No * What is your

Current complaint?----------=

Have you had issues with your neck or back prior to this accident?_____Yes_____No

Date of injury or onset of symptoms:__/__/____

Is there possibility that you are pregnant?_____Yes_____No

Personal history of: (Circle all that apply)_Diabetes_High Blood Pressure_Heart Disease

Stroke Sinus Pain_Osteoporosis _Mitral Valve Prolapse _Irreg Heartbeat_ Blood Clots_

Raynauds _Asthma_Tuberculosis Pneumonia Sleep Apnea Kidney Stones_ HIV or AIDS

__Sickle Cell UlcerDisease_Thyroid Cancer/type_____Other_____

LIST CURRENT MEDICATIONS: Include prescriptions, over-the-counter, and herbal medications.

_____

_____

_____

_____

KNOWN DRUG ALLERGIES? ___No____Yes, list._____

_____

Past Surgical History: Operation and year

_____

_____

_____

FAMILY MEDICAL HISTORY:

Who, if anyone, has or has had any of the following:

Diabetes:_____ High Blood Pressure:_____

Heart Disease:_____ Cancer _____

Stroke: _____

SOCIAL HISTORY: tobacco use: Never ---'Previously, but quit_____Packs per day_____

Alcohol use: Never_____Rarely_____Moderately_____Daily____History of Alcoholism_____

Illegal or street drugs: Never_____Type/Frequency_____History of Abuse_____

Marital Status: Single___Married____Separated____Divorced____Widowed___

Occupation: _____ Duties: _____

Retired _____

IF ACCIDENT OR INURY: Are you working? YES or NO Restrictions? YES or NO

If no, last day worked?_____Does your employer have light duty? YES or NO or UNKNOWN

Have you been injured on the job before? YES or NO If yes, body part?_____

Are you on any special diet?_____

Do you CURRENTLY exercise? YES or NO If yes, what type and how many times per week?_____

_____

Hobbies: _____ Sports:_____

Name, phone#, and address of your medical doctor:_____

_____

Name,phone#,andaddressofyourpharmacy: _____

_____

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MEDICAL HISTORY:

Medical Tests Already Done: _X RAYS _MRI _CAT SCAN _BONE SCAN

_MYELOGRAM _EMG / NCS OTHER:_____

If so, have you seen any other doctor for this problem? (List below)

_____

_____

_____

What type(s) oftreatment(s) have you received for your back or neck?

_____

What aggravates or makes your pain worse? (Circle all that apply)

During Exercise Stress Bending Forward Damp Weather

After Exercise Sex Bending Backward Cold Weather

Sitting Coughing Morning Fatigue

Standing Sneezing Night Touching Skin

Walking Twisting Work Activities Other

_____

What relieves or lessens your pain? (Circle all that apply)

Lying Down Heat/Massage Injections Alcohol

Sitting Medications Exercise Ice

Standing Walking Physical Therapy Nothing

Other _____

What activities of daily living can you do now? (Circle all that apply)

Drive Housework Work at a Job Climb Stairs

Walk Sit Stand Get Dressed Yard Work

MEDICAL HISTORY:

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

Diabetes:---------- High Blood Pressure:----------

Heart Disease:_____Cancer:----------

REVIEW OF SYSTEMS:

GeneraVConstitutional: --fever-chills-fatigue-night sweats-weight gain-weight loss

ENT:

Tooth/Gum Trouble-difficulty hearing-sinus problems-ringing in ears

OPTHALMOLOGIC:

Changes in vision

MUSCULOSKELETAL:

neck pain-mid back pain-:-low back pain-joint pain/swelling-weakness-arthritis--fibromyalgia

CARDIOVASCULAR:

Chest pain-high blood pressure-leg pain with exercise

RESPIRATORY :

Asthma-difficulty breathing-cough -wheezing-

GENITOURlNAR Y:

Blood in urine-difficulty urinating-painful urination-nocturia -sexual dysfunction

HEMATOLOGY:

Anemia-easy bruising-swollen glands

NEUROLOGIC:

Coordination loss-dizziness-headache-memory loss-tingling/numbness

PSYCHIATRIC :

Depression -sleeping disorder-anxiety

GASTROINTESTINAL:

Abdominal pain-blood in stool-constipation-diarrhea-heartburn/indigestion-nausealvomiting(not caused by flu)-Irritable bowel syndrome

ENDOCRINE:

Thyroid disorder-excessive thirst-frequent Urination

SKIN:

Itching--rash

PAIN INTENSITY RATING

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

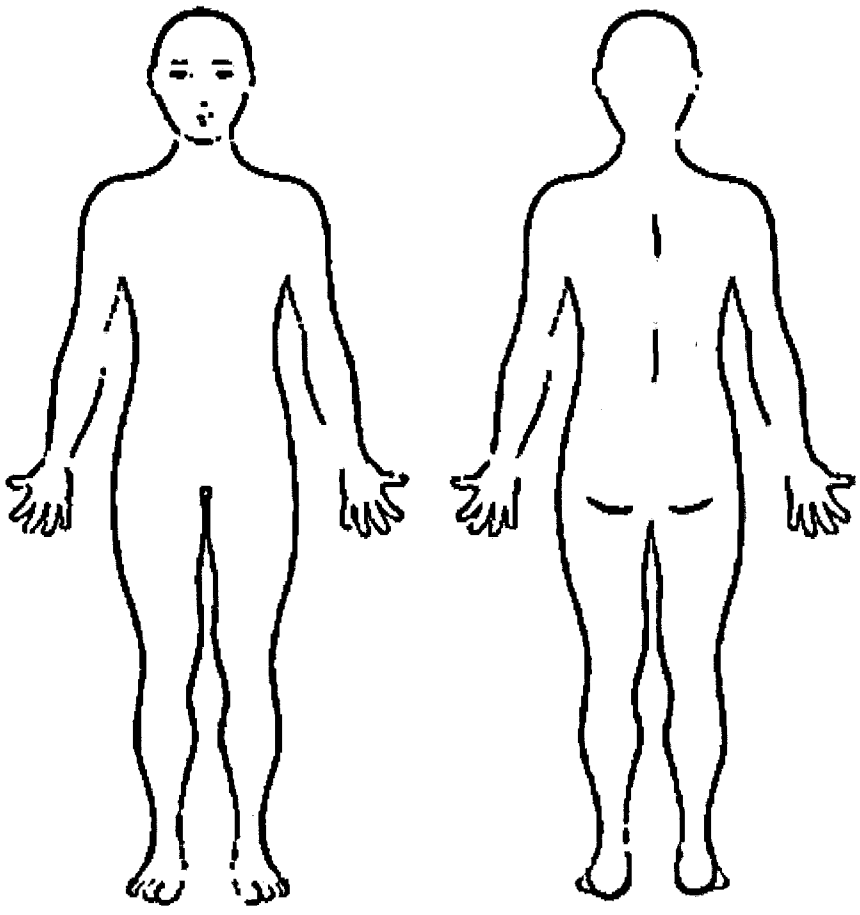
No Pain — Worst Possible

0% 10 20 30 40 50 60 70 80 90 100%

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/Needles = Stabbing / Ache A



Physician Initials: _____ Date: _____