Orthopedic Sports Medicine & Spine Care Inst.

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__Glaucoma __High Blood Pressure __Heart Disease __Stroke__ Sinus Pain __Osteoporosis __Mitral Valve Prolapse__Irreg Heartbeat__ Blood Clots__ Raynaud's __Asthma _Tuberculosis__ Pneumonia __Sleep Apnea__ Kidney Stones__ HIV or AIDS __Sickle-Cell __Ulcer Disease __Thyroid __Kidney stones__ 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 #, and address of your PHARMACY: ______________________________________

____

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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) of treatment(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

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(Circle all that apply)

REVIEW OF SYSTEMS:
General/Constitutional: --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—

GENITOURINARY:
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—nausea/vomiting(not caused by flu)—Irritable bowel syndrome

ENDOCRINE:
Thyroid disorder—excessive thirst—frequent urination

SKIN:
Itching--rash

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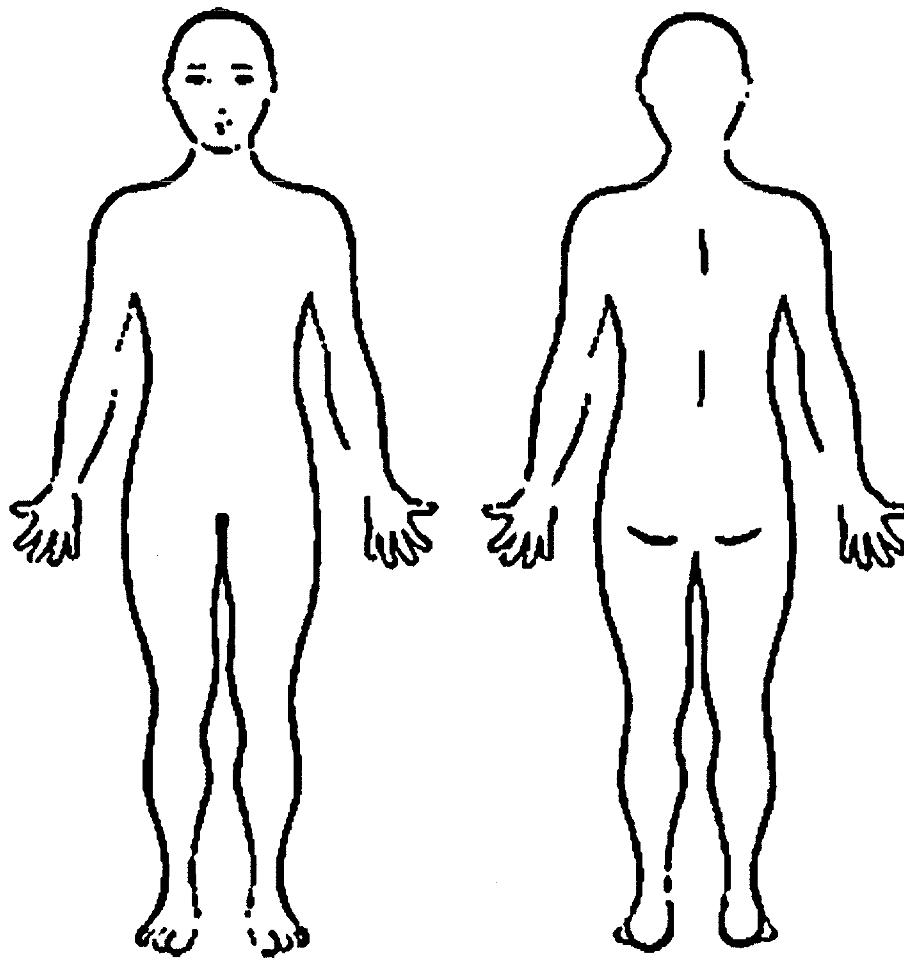
PAIN INTENSITY RATING
On the line below, CIRCLE your AVERAGE PAIN over this last week.

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: ______________