Patient Questionnaire and Medical History

Patient Name: ____________________________ Date: ____________________

Date of Birth: _____________________________ Age: _____________________

Email: ____

Address: ____

____

Ph: (____)______-______. Secondary Contact Information (Name, Ph#)

Cell: (____)______-______. ______________________________________

Primary Insurance: ____

Secondary Insurance: ____

PRIMARY CARE PHYSICIAN

Primary Care Physician (PCP): ____

PCP Address: ________________________________ PCP Ph: (___)___-____.

________________________________ PCP Fax: (___)___-____.

HOW DID YOU HEAR ABOUT EXPERT SPINE CARE?

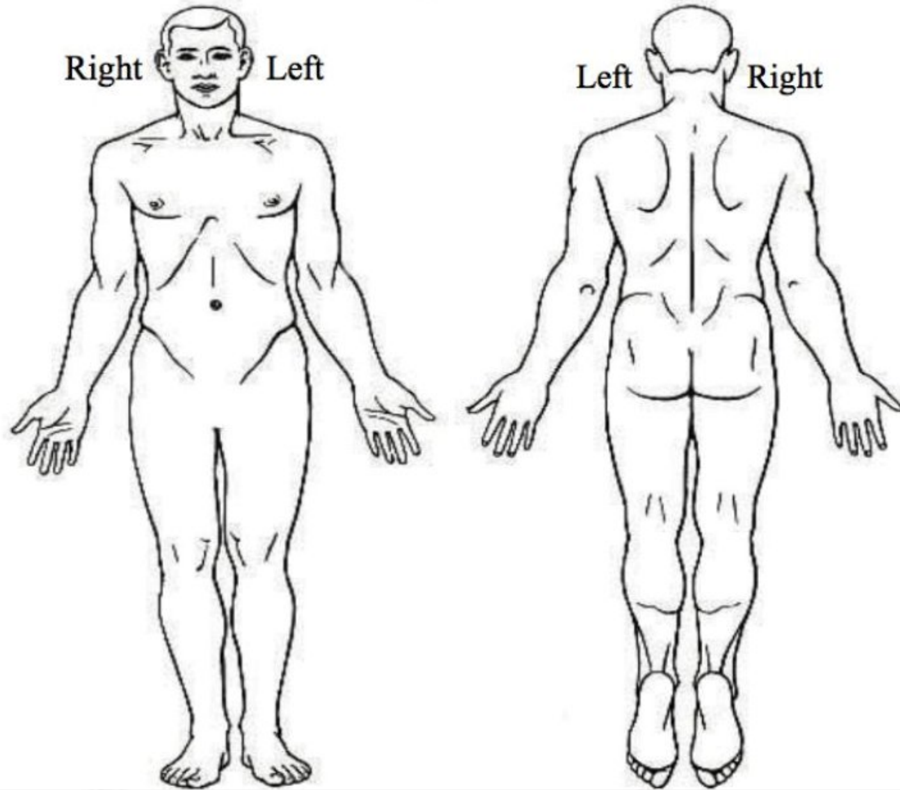
- ☐ Referral from Physician? (Name of Physician ___________________________________)
- ☐ Internet? ☐ Google Search ☐ Bing ☐ Other: ________________________
- ☐ Family / Friend? (Name of Family/Friend ____________________________________)
- ☐ Other? (Please Describe ____)

WORKER'S COMPENSATION/LEGAL STATUS

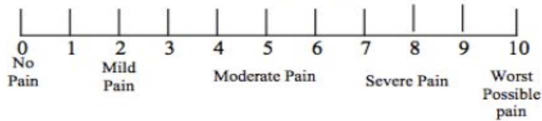
Is your medical claim related to a work related injury? ☐ No ☐ Yes ☐ Applying
Is there pending legal proceedings? ☐ No ☐ Yes ☐ Applying

Patient Name: ____________________________ Date: ____________________

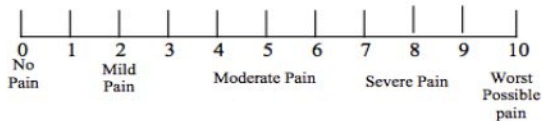
Please mark an "X" on the body part(s) where you have pain.
Mark a "0" on the body parts where you have numbness.



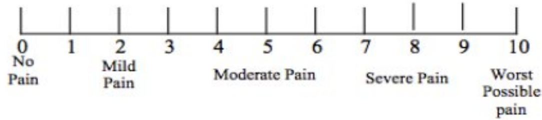
NECK



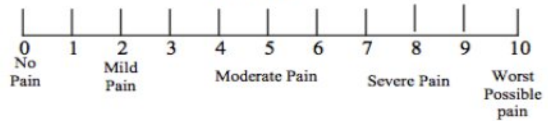
RIGHT ARM



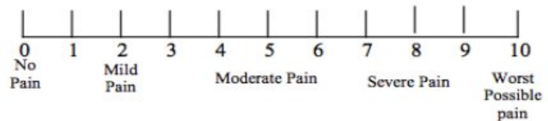
LEFT ARM



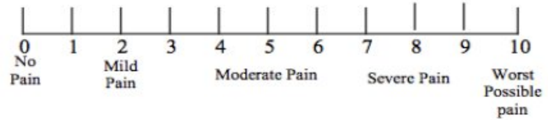
BACK



RIGHT LEG



LEFT LEG



EXPERT SPINE CARE
INNOVATIVE MINIMALLY INVASIVE TREATMENT

Patient Name: ___________________________ Date: ____________________

BRIEFLY EXPLAIN WHAT WE ARE EVAULATING TODAY?

Complaint #1: ____

Complaint #2: ____

Date of Onset of Symptoms/Injury: ____________________________________

Is Visit Related to Automobile Accident? □ No □ Yes (Date of Accident? _____)
Is Visit Related to Work Related Injury? □ No □ Yes
Was the Injury Reported to the Employer? □ No □ Yes (Date of Report? _____)

How Often Do You Suffer From the Pain? □ Daily □ Weekly □ Monthly □ Yearly
Describe Your Pain: □ Burning □ Aching □ Stabbing □ Pins/Needles □ Numbness
For Joint Related Pain, Do You Have? □ Locking □ Catching □ Instability

What Makes Your Pain/Symptoms Worse?
□ Bending □ Lifting □ Twisting □ Siting □ Standing □ Overhead work
□ Walking (How many blocks can you walk without pain? ______) □ Sneezing
□ Coughing □ Intercourse □ Other: ______________________________________

What Makes Your Pain/Symptoms Better?
□ Leaning forward □ Leaning backward □ Leaning to side □ Laying flat □ Resting
□ Hot Baths □ Heat □ Ice □ Massage □ Brace □ NSAIDs □ Narcotics □ Elevation
□ Other: ____

Associated Signs and Symptoms:
□ Altered Gait □ Loss of Balance □ Dropping Things □ Loss of Bowel Control
□ Loss of Bladder Control □ Swelling □ Redness □ Numbness/Tingling

Do you Experience Weakness in the Upper Extremities? □ Left □ Right □ Both
Do you Experience Weakness in the Lower Extremities? □ Left □ Right □ Both

How is the Quality of your Life? □ Excellent □ Good □ Fair □ Poor □ Horrible

Patient Name: ______________________________ Date: ______________________

Prior Treatments For Your Condition

☐ Anti-inflammatory Medications:
- Which one? ____________________________ Did it help? ☐ No ☐ Yes

☐ Muscle Relaxers:
- Which one? ____________________________ Did it help? ☐ No ☐ Yes

☐ Oral steroids:
- Which one? ____________________________ Did it help? ☐ No ☐ Yes

☐ Pain Medications:
- Which one? ____________________________ Did it help? ☐ No ☐ Yes

☐ Physical Therapy:
- Date of last visit? _________ How Many Visits? _____ Did it help? ☐ No ☐ Yes

☐ Chiropractic Intervention:
- Date of last visit? _________ How Many Visits? _____ Did it help? ☐ No ☐ Yes

☐ Epidural Steroid Injections:
- Date of Last Inj. ________ How Many Injections? ___ Did it help? ☐ No ☐ Yes

☐ Other: ____

Physicians Who Have Treated Your Condition?

Name of Physician	Last Treatment Date
____	__________________________________
____	__________________________________

List All Diagnostic Studies Related to your Condition:

	Date of Study	Location of Study
☐ X-rays	____________________	____
☐ MRI	______________________	____
☐ CT-scan	___________________	____
☐ EMG	_____________________	____
☐ Nerve Study	________________	____

What Do You Want to Happen as a Result of This Visit?

____

____

EXPERT SPINE CARE
INNOVATIVE MINIMALLY INVASIVE TREATMENT

Patient Name: ___________________________ Date: ____________________

PAST MEDICAL HISTORY

☐ AIDS/HIV	☐ Depression	☐ Heart Attack/Angina	☐ Osteoporosis
☐ Anemia	☐ Diabetes	☐ Hepatitis C	☐ Vascular Disease
☐ Anxiety	☐ Diverticulosis	☐ High Blood Pressure	☐ Polio
☐ Arthritis	☐ Ear Trouble	☐ HIV	☐ Psychiatric
☐ Asthma	☐ Endometriosis	☐ Irregular Heart Beat	☐ Rheumatic Fever
☐ Bipolar Disorder	☐ Enlarged Prostate	☐ Irritable Bowel Syndrome	☐ Scoliosis
☐ Cancer	☐ Fibromyalgia	☐ Jaundice	☐ Seizures
☐ Colon Polyp	☐ Gastritis	☐ Kidney Disease	☐ S.T.D.s
☐ Congestive Heart	☐ Glaucoma	☐ Kidney Stones	☐ Stroke
☐ COPD	☐ Gout	☐ Liver Disease	☐ Thyroid Disease
☐ Blood Clots	☐ Head Injury	☐ Lupus	☐ Tuberculosis

☐ Other Medical Problems: ______________________________ ☐ Ulcers

☐ Date of Last Menstrual Cycle: _______ Are You Pregnant? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Month/Year	Type of Surgery	Surgeon
______________	_____________________________	_____________________
______________	_____________________________	_____________________
______________	_____________________________	_____________________

(If you have multiple surgeries, please provide all surgeries on a separate list)

EMPLOYMENT

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Retired (How Many Yrs?____)

Job Description: ____

Place of Employment: ____

Length of Employment (Months or Years): ______________________________

Are You on Work Restrictions? ☐ No ☐ Yes (Current Restrictions? _________)

Patient Name: ___________________________ Date: ____________________

Are You Disabled? □ No □ Yes (Number of Years Disabled: _______________)

Reason for Disability? _____________________ Percent Disabled: ________%

CURRENT MEDICATIONS

Drug (Ex: gabapentin)	Dosage (600 mg)	Frequency (three times/day)

(If you have multiple medications, please provide all medications on a separate list)

ALLERGIES (MEDICATIONS, METAL)

Allergen (Ex: penicillin)	Reaction (rash)

(If you have multiple allergies, please provide all allergies on a separate list)

SOCIAL HISTORY

Marital Status? □ Single □ Married □ Divorced □ Widowed □ Domestic Partner
Highest Level of Education: □ GED □ H.S. □ Associates □ Bachelors
□ Masters □ Ph.D. □ J.D. □ M.D./D.O. □ Trade Degree □ Other: __________
What is your Degree Specialty? ______________________________________
Tobacco History? □ No □ Yes
□ Active (Packs/per day? _____) □ Quit (How long? ______)
If you become a surgical candidate, are you willing to quit? □ No □ Yes
Do you drink alcohol excessively? □ No □ Yes (Alcoholic drinks per day? _______)
Do you actively use illicit drugs? □ No □ Yes (Which ones? ____________________)

Patient Name: ______________________________ Date: ______________________

FAMILY HISTORY

Father: □ Alive / Age: ____________________ Good Health? □ Yes □ No
Suffers With? ____
□ Deceased / Age: ________________ Cause? _____________________

Mother: □ Alive / Age: ____________________ Good Health? □ Yes □ No
Suffers With? ____
□ Deceased / Age: ________________ Cause? _____________________

Brother: □ Alive / Age: ____________________ Good Health? □ Yes □ No
Suffers With? ____
□ Deceased / Age: ________________ Cause? _____________________

Sister: □ Alive / Age: ____________________ Good Health? □ Yes □ No
Suffers With? ____
□ Deceased / Age: ________________ Cause? _____________________

Medical conditions that 1st degree family members suffer from?

____

____

FOR CONDITIONS PENDING LITIGATION:

Attorney Name, Group: ____

Attorney Address: _________________________________ Ph: ( ) - .

_________________________________ Fax: ( ) - .

Patient Name: ______________________________ Date: ______________________

Review of Symptoms

In the past 3 months, have you experienced any of the following? Please put a check mark in front of any/all of the following that you have experienced. If you have experienced any of these symptoms, please be sure to notify your Primary Care Physician.

GENERAL

- ☐ Weight Gain _____ lbs.
- ☐ Weight Loss _____ lbs.
- ☐ Fever
- ☐ Chills
- ☐ Loss of Energy
- ☐ Difficulty Sleeping
- ☐ Change in Appetite
- ☐ Headaches
- ☐ Cold/Heat Intolerance
- ☐ Night Sweats
- ☐ Swelling of Feet
- ☐ Blood Clots
- ☐ Other: _______

URINARY

- ☐ Spontaneous Urinating
- ☐ Discharge
- ☐ Difficulty Starting Stream
- ☐ Other: _______

PSYCHOLOGIC

- ☐ Anxiety
- ☐ Stress
- ☐ Depression
- ☐ Suicidal Thoughts
- ☐ Other: _______

H.E.E.N.T

- ☐ Change in Vision
- ☐ Blurred Vision
- ☐ Dry Eyes
- ☐ Sore Throat
- ☐ Nosebleeds
- ☐ Nasal Congestion
- ☐ Change in Hearing
- ☐ Hard of Hearing
- ☐ Other: _______

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody Stools
- ☐ Spontaneous Defecation
- ☐ Other: _______

PULMONARY

- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Other: _______

CARDIOVASCULAR

- ☐ Chest Pain/Discomfort
- ☐ Swelling of Lower Legs
- ☐ Other: _______

SKIN

- ☐ Moles
- ☐ Skin Rash
- ☐ Infections
- ☐ Change in Moles
- ☐ Other: _______

LIST ANY OTHER SYMPTOMS YOU HAVE EXPERIENCED AND ARE CONCERNED ABOUT

____
____
____
____