

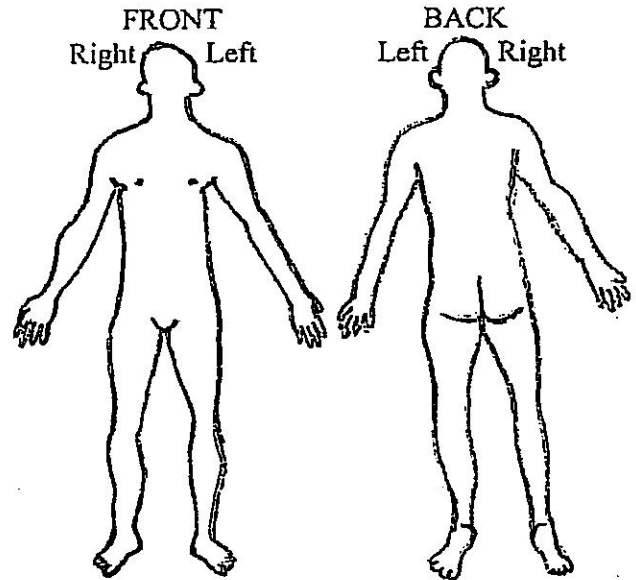
Tidewater Physicians Multispecialty Group – Spine Division

Name: _____ Date: _____ Age: _____ ☐ F ☐ M Ht _____ Wt _____

Why are you here today?

Did a physician refer you? If so, who? _____

What body part is involved? Does your pain radiate?
Use the provided diagram for assistance.



How long ago did it start? DATE (if known): _____
OR (Days _____)(Weeks _____)(Months _____)(Years _____)

What BEST describes how your problem started?

NO INJURY – Onset was ☐ Gradual or ☐ Sudden

INJURY – ☐ Accidental ☐ Sport (not auto or work)

INJURY AT WORK –

Date: _____ Have an attorney? ☐ Y ☐ N

AUTO ACCIDENT –

Date: _____ Have an attorney? ☐ Y ☐ N

Have you had a problem like this before? ☐ Y ☐ N

Comments: _____

How bad is your pain on a scale of 1-10? (1 = minimal, 10 = worst imaginable) (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

Does the pain: ☐ Occur constantly? ☐ Come and go? ☐ Wake you from sleep?

Associated with this issue, do you have: ☐ Swelling? ☐ Bruising? ☐ Numbness? ☐ Tingling? ☐ Weakness? ☐ Loss of control of bowel or bladder function? ☐ Fever/chills? ☐ Weight loss? ☐ Night sweats?

What makes your symptoms worse? ☐ Prolonged standing ☐ Standing up ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting
☐ Lying down ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing/sneezing
☐ Other _____

What makes your symptoms better? ☐ Ice ☐ Heat ☐ Lying down ☐ Reclining ☐ Sitting ☐ Standing ☐ Bending forward ☐ Other _____

Do any medications relieve your pain? (please list) _____

Were you seen in the ER for this problem? ☐ Y ☐ N If yes, which ER?
Date: _____

What medications are you taking now FOR THIS PROBLEM?

What tests/scans have you had for this problem? ☐ X-Ray ☐ MRI ☐ CT scan ☐ Bone scan ☐ Nerve test(EMG/NCV)
Where/when were these taken? _____

Current work status: ☐ Regular duty ☐ Light duty ☐ Not working due to problem ☐ Retired ☐ Student

Past Medical History (prior and current)

- | | | |
|---|--|---|
| ☐ Heart attacks (Year(s)_____) | ☐ Kidney disease | ☐ Gallbladder disease |
| ☐ Heart rhythm problems (Type, if known_____) | ☐ Kidney stones | ☐ Tuberculosis |
| ☐ Heart failure | ☐ Prostate disease | ☐ Venereal disease (Type_____) |
| ☐ High blood pressure | ☐ Hepatitis (Type_____) | ☐ HIV positive |
| ☐ High cholesterol | ☐ Cancer (Type_____) | |
| ☐ Strokes (Year(s)_____) | ☐ Diabetes | ☐ Hiatal hernia |
| ☐ Chronic bronchitis/Emphysema | ☐ Anemia | ☐ Gout |
| ☐ Ulcers | ☐ Acid reflux/GERD | ☐ Rheumatoid arthritis |
| ☐ Pneumonia | ☐ Osteoporosis | ☐ Thyroid problems |
| ☐ Asthma | ☐ Glaucoma | ☐ Anxiety/depression |
| ☐ History of blood transfusions (When/for what reason?_____) | | |

Past Surgical History (procedure/approximate dates)

Medications

Allergies(medication AND reaction)

Do you have any adverse reaction to anti-inflammatories or pain medications? If so, please include above.

<u>Family History</u>	Father	Mother	Brother	Sister	Children
☐ Cancer(type?)	_____	_____	_____	_____	_____
☐ Bleeding disorder	_____	_____	_____	_____	_____
☐ Other(please list)	_____	_____	_____	_____	_____

Social History

- Do you or did you smoke? ☐N ☐Y If so, how much, and for how long? _____ Year quit _____
- Do you drink alcohol? ☐N ☐Y If so, how much, how often, and what type? _____
- Have you ever used illicit drugs? ☐N ☐Y Type: _____
- Are you: ☐Single ☐Married ☐Divorced ☐Widowed
- Do you have children? _____
- Do you live alone? ☐N ☐Y
- Do you use a device to help you move about? ☐N ☐Y If so: ☐Cane ☐Walker ☐Wheelchair ☐Other _____
- What type of work do you do? _____ Activities/hobbies _____

Review of Symptoms: Associated with your CURRENT problem, please circle the symptoms that apply to you.

Fever, chills, night sweats, general fatigue, unintentional weight loss, chest pain, shortness of breath, cough, headaches, loss of appetite, abdominal pain, nausea, vomiting, leg swelling, sleeping difficulty, bowel irregularity, bowel incontinence, urinary incontinence, sexual dysfunction, anxiety, depression, poor coordination, trouble walking, skin rashes, joint swelling, knee or other joint pain, neck pain, dizziness, fainting, frequent infections, frequent falls

Comments: _____
