

Tidewater Physicians Multispecialty Group- Spine Division

Name: _____ Date: _____ Age: _____ F M HI _____ WI _____

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

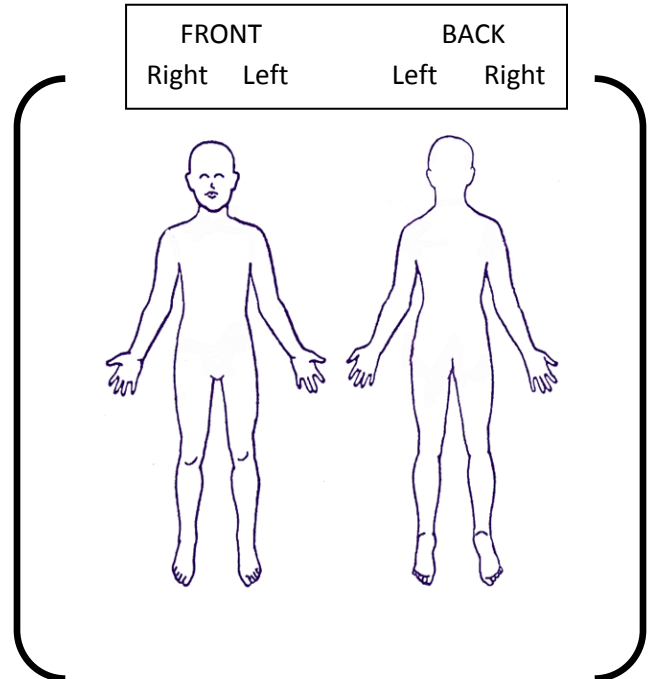
INJURY- _____ Accidental _____ Sport (not auto or work)

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 scale of 1-10? (1=minimal, 10= worst imaginable) (circle) 0 1 2 3 4 5 6 7 8 9 10

Please check the line that applies to your visit today with each question below:

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 _____ Exercises
_____ Twisting _____ Lying down _____ Bending _____ Squatting _____ Kneeling _____ Stairs _____ Sitting _____ Coughing/sneezing

Other: _____

What makes your symptoms better? _____ Ice _____ Heat _____ Laying 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 test/scans have you had for this problem? _____ Xray _____ 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

TURN OVER

Past Medical History (prior and current)

- | | | |
|---|--|--|
| ☐ Heart attacks (Year(s)_____) | ☐ Kidney disease | ☐ Gallbladder disease |
| ☐ Heart rhythm | ☐ 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 transfusion (When/for what reason? _____) | | |

Past Surgical History (procedure/ approximate date)

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 Who do you live with? _____

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, dizziness, fainting, frequent infections, frequent falls

Comments: _____
