NEUROSPINE
SURGICAL CONSULTANTS

Patient History of Present Problem

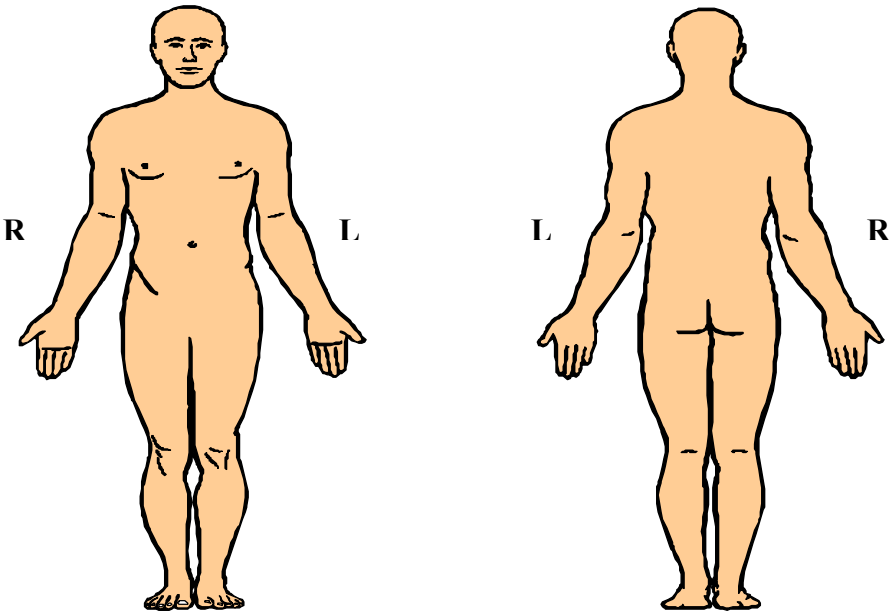
Patient name:_____ **Date:**_____
Age: _____ **Race:**_____ **R or L handed** **Sex: Male Female**

In one sentence or less, please state the reason you are seeking a surgical evaluation:

_____

Mark the areas on your body where you feel the described sensations by using the appropriate symbol.

Ache: ^^^^ **Numbness:** OOOO **Pins & Needles:** = = = = **Burning:** XXXX **Stabbing:** ////



Are you experiencing any of the following symptoms:

- ❒ Radiating pain
- ❒ Numbness (loss of sensation)
- ❒ Tingling
- ❒ Loss of control of bowels or bladder
- ❒ Weakness in arms or legs
- ❒ Gait changes
- ❒ Headaches
- ❒ Problems controlling your fingers

Please mark the level of your pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Possible**

Since their onset, have the symptoms: ❑ Improved ❑ Remained the same/leveled off ❑ Progressively worsened

List two physical activities which aggravate your pain: _____

List two physical activities/positions which make the pain better: _____

Is the pain the result of an injury? ❑ Yes ❑ No ❑ Unsure – please explain:_____

If this is an injury, is it: ❑ Work related ❑ Motor vehicle related ❑ Other: _____

What is the date of injury? _____ If not an injury, date symptoms began:_____ Have you missed work because of your pain? ❑Yes ❑ No If yes, how long? _____

Briefly describe how your injury occurred or how the symptoms began:_____

_____

_____

When (date) did you begin to seek medical care for your symptoms? _____

Who did you seek treatment from (physician name/specialty):_____

Please list all other physicians you have sought treatment or opinions from:

_____

_____

Patient name:_____

Please mark all diagnostics done with dates: ❑ MRI _____ ❑ CT/Myelogram _____ ❑ Discogram _____

❑ EMG/NVC _____ ❑ X-Ray _____ ❑ Other_____

What treatments have you tried to help alleviate your symptoms (please mark only those tried recently – in less than 2 years)

❑ Physical therapy ❑ Epidural Steroid Injections (ESI's) ❑ Anti-inflammatory medication ❑ Oral Steroids ❑ Facet injections ❑Pain management program ❑Activity modification ❑Chiropractic adjustments ❑ Other_____

Medication Information

List all medications to which you are allergic:

_____

Please list any medications you are currently taking (include over the counter and herbals). Please include dosages.

_____ _____

_____ _____

_____ _____

Past Surgical History

Starting with the most recent, please list in date order any **SPINE** surgeries you may have had:

_____ _____

Date Operation Date Operation

_____ _____

Date Operation Date Operation

Starting with the most recent, please list any other types of surgery you may have had:

_____ _____

Date Operation Date Operation

_____ _____

Date Operation Date Operation

Family History

Family Member	Living	Deceased	Age	Health Status or Cause of Death
Mother	❑	❑	_____	_____
Father	❑	❑	_____	_____
Brother/Sister	❑	❑	_____	_____
Brother/Sister	❑	❑	_____	_____
Grandmother (mom's)	❑	❑	_____	_____
Grandfather (mom's)	❑	❑	_____	_____
Grandmother (dad's)	❑	❑	_____	_____
Grandfather (dad's)	❑	❑	_____	_____

Social History

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Occupation:_____ Do you have children? ❑ Yes ❑ No If yes, how many?_____

Do you live alone? ❑ Yes ❑ No If no, who lives with you?_____

Do you **smoke**? ❑ Yes ❑ No If Yes, how many packs per day? _____ For how long? _____

If you are a former smoker, how long ago did you quit? _____ How many packs per day were you smoking?_____

Do you drink **alcohol**? ❑No ❑Rarely ❑No, but I used to ❑Yes, daily ❑Yes, 1 or more times a week ❑Yes, socially

Are you at risk for AIDS (e.g. sexual orientation, history of drug use, previous blood transfusion)? ❑ Yes ❑ No