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Board Certified Spine Surgeon
American Board of Orthopedic Surgery

PATIENT INFORMATION PACKET

(Check All That Apply)

PATIENT NAME: _____

DATE OF BIRTH: _____

PHARMACY NAME: _____

PHARMACY PHONE #: _____

PHARMACY ADDRESS: _____

Primary Care Physician's Name: _____
☐ **Don't have a Primary Care Physician.**

Signature Verification

SIGN HERE / FIRME AQUI: _____

If your visit or encounter is witnessed or if an interpreter accompanies you, it is important for the proper identification of the person(s) verifying your signature.

_____
Witness/ Name

_____
Translator/Interpreter Name

_____
Address

_____
City, State, Zip

If the patient is a minor or under legal guardianship by my signature as a guardian, I authorize evaluation and medically necessary tests and treatment.

_____
Signature of Parent /Guardian

BEFORE YOU CONTINUE

We know that filling out all these forms can be annoying - but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this information, we can provide you the best medical care possible.

So, please help us and you, by taking the extra time required to answer the appropriate questions accurately. Be careful to follow the directions in each section. You may be prompted to answer all questions in a section or to move on to the next section. Clearly mark in appropriate space, circle appropriate items or write legibly where indicated.

Thank you for your cooperation.

I. VITALS:

WEIGHT:_____ HEIGHT:_____

II. CHIEF COMPLAINT for this visit is:

☐ **Low back** ☐ **Leg pain** ☐ **Mid back pain** ☐ **Neck pain** ☐ **Arm pain**

III. HPI:

1. Mechanism of Injury:

☐ **Unknown**
☐ **Rotation/Twist**
☐ **Trauma** ☐ **Severe** ☐ **Mild**
☐ **Lifting** ☐ **At Work?**
☐ **Car Accident** ☐ **At Work?** ☐ **Seat belt used?**
☐ **Slip and Fall** ☐ **At Work?**
☐ **Work Environment**

Explain: _____

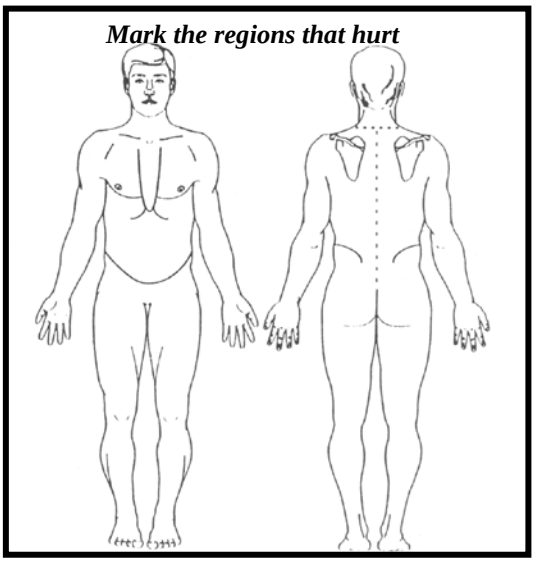
2. Onset and Resolution:

☐ **Date of injury: ___/___/___** ☐ **It is recurrent- It comes and goes**
☐ **Gradual Onset of Symptoms** ☐ **Sudden Onset of Symptoms**
☐ **Getting Better** ☐ **Getting Worse**
☐ **Symptoms Stable in Severity**

Describe: _____

How long have the symptoms been present? _____

3. Symptom Severity [Use a scale of 0 (no pain) to 10 (severe)]



How is your neck pain today? ____

How is your *right* arm pain today? ____

How is your *left* arm pain today? ____

How is your middle back pain today? ____

How is your low back pain today? ____

How is your *right* leg pain today? ____

How is your *left* leg pain today? ____

4. Associated Complaints: (check all that apply)

☐ **Numbness (loss of feeling) in: __ arms/hands __ legs/feet**
☐ **Tingling (falling asleep) in: __ arms/hands __ legs/feet**
☐ **Weakness of muscles in: __ arms/hands __ legs/feet**
☐ **My legs fatigue when I walk too far.** ☐ **My leg pains are relieved by resting my legs**

5. Exacerbating (Worsening) Factors: (check all that apply)

☐ **in the morning** ☐ **in the late afternoon** ☐ **at night when sleeping**
☐ **with coughing/sneezing (Valsalva)**
☐ **when I lean forward** ☐ **when I lean back** ☐ **when I lie down**

6. Alleviating Factors (Makes Pain Better): (check all that apply)

☐ **when I sit down** ☐ **when I lie down.**
☐ **when I lean forward** ☐ **when I lean back** ☐ **when I push on a shopping cart**

Oswestry Questions:

Pain Severity
- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Personal Care
- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, I wash with difficulty and stay in bed

Lifting
- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights.
- I can lift very light weights
- I cannot lift or carry anything at all

Walking
- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than ¼ mile
- I can only walk using a stick or crutches
- I am in bed most of the time

Sitting
- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Standing
- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Sleeping
- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Sex Life
- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Social Life
- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life, apart from limiting sports/exercise
- Pain has restricted my social life, and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Traveling
- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad, but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys < 30 minutes
- Pain prevents me from travelling except to receive treatment

IV. Patient History:

I write with my RIGHT / LEFT Hand.

PLACE A CHECK NEXT TO ANY DISEASE THAT APPLIES TO YOU:

1. None: ☐

2. Heart:
☐ angina/chest pain
☐ myocardial infarction (heart attack)
☐ cardiac murmur
☐ valve disease
☐ arrthymia
☐ other: _____

3. Vascular:
☐ hypertension (high blood pressure)
☐ stroke
☐ transient ischemic attack (TIA)
☐ varicose veins

4. Ulcers/Digestive System:
☐ stomach/duodenal ulcer
☐ irritable bowel syndrome
☐ incontinence (bowel)

5. Diabetes (high blood sugar):
☐ insulin dependent
☐ non-insulin dependent (pills/diet)

6. Liver Disease:
☐ hepatitis (A / B / C)
☐ cholelithiasis (gallstone)

7. Kidney Disease:
☐ nephrolithiasis (kidney stone)
☐ urinary tract infections
☐ kidney failure/dialysis
☐ incontinence (urine)

8. Lung Disease:
☐ COPD
☐ emphysema
☐ TB
☐ bronchitis
☐ pneumonia
☐ asthma
☐ other: _____

9. Blood Disorders:
☐ anemia
☐ leukemia
☐ bleeding disorder

10. Eye Disease:
☐ glaucoma
☐ cataracts
☐ other: _____

11. Ear Disease:
☐ hearing loss
☐ ringing (tinnitus)

12. Endocrine Disease:
☐ thyroid
☐ parathyroid
☐ pituitary
☐ adrenal

13. Skin Disease:
☐ psoriasis
☐ problems healing

14. Arthritis:
☐ degenerative
☐ rheumatoid
☐ gout
☐ psoriatic

15. Cancer:
☐ Type: _____

16. Psychological Difficulties:
☐ depression
☐ psychosis
☐ anxiety

17. Ladies:
☐ currently pregnant (# of weeks? ___)
☐ menstrual problems

18. Men:
☐ discharge
☐ problems with sexual function
☐ prostate issues
☐ other: _____

19. Childhood Disease:
☐ rheumatic fever
☐ epilepsy
☐ polio

Allergies:
To Medicines: ☐ None ☐ Penicillin ☐ Sulfa ☐ Other: _____
To Foods: ☐ None ☐ Shellfish ☐ Other: _____
Skin: ☐ None ☐ Latex ☐ Tape ☐ Iodine ☐ Other: _____

☐ **Currently Not Taking Any Medications**
Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

[Note: We will also review medications from the national pharmacy database.]

Major Surgeries (If yes, When):
☐ None
☐ Tonsillectomy: _____
☐ Appendectomy: _____
☐ Gall Bladder: _____
☐ Heart: _____
☐ Digestive: _____
☐ Other: _____
☐ Hysterectomy: _____
☐ Vasectomy: _____
☐ Biopsy: _____
☐ Fracture Repair: _____
☐ Joint Repair: _____
☐ Hernia: _____

Spinal Surgery	Surgeon	Date of Surgery	No Help	Some Relief	Good Relief
Discectomy					
Laminectomy					
Lumbar Fusion					
Spinal Instrumentation					
Lumbar Arthroplasty					
Scoliosis					
Revision Surgery					
Cervical Fusion					
Cervical Arthroplasty					
Kyphoplasty					

Infection History:
☐ Hepatitis B positive
☐ HIV positive
☐ History of Tuberculosis (Tb) exposure
☐ Hepatitis C positive
☐ Methicillin Resistant Staph (MRSA)

Specialty Q and A:

Major Injuries: ☐ **None**
Automobile/ Motorcycle: _____

Prior Work Injury: _____

Prior sports or misc. injuries: _____

Previous Treating Doctors:

Doctor's Name	Specialty	Location	Date of Treatment

Previous tests for this condition:

TYPE	WHEN	FACILITY	RESULTS
Regular x-rays			
CAT Scan			
MRI Scan			
Myelograms			
Discography			
Nerve Tests			

Therapies	No Help	Some Relief	Good Relief
Physical Therapy			
Chiropractic Care			
Epidural			
Facet Injection			
Rhizotomy			
Nucleoplasty			
Accupuncture			
Traction Table			
"Laser" surgery			
Massage			

FAMILY/SOCIAL AND LIFESTYLE

Family Medical History:

Mother: ☐ **Alive - Age _____** ☐ **Good Health** ☐ **Suffers with: _____**
☐ **Deceased - Cause: _____**
Father: ☐ **Alive - Age _____** ☐ **Good Health** ☐ **Suffers with: _____**
☐ **Deceased - Cause: _____**
I have ☐ **Living ( )brothers/( )sisters**
☐ **Deceased ( )brothers/( )sisters, cause(s): _____**

Social History: **(check all that apply)**

☐**Single** ☐**Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

☐ **I work as a _____ Previous occupation(s) _____**
☐ **I am retired** ☐ **I am not working because of my back/neck (since _____)**

Highest educational level attained:
☐**Grammar** ☐**High School** ☐**College** ☐**Post Graduate**

☐ **I live with my children or other relatives.** ☐ **I live by myself.**
☐ **I have special needs. Explain: _____**

I drink:
☐ **None**
☐ **Beer**
☐ **Wine**
☐ **"Hard drinks"**
Frequency: ☐ **rarely** ☐**socially** ☐**daily Quantity: _____**

My use of tobacco:
☐ **Current Every Day Smoker**
☐ **Current Some Day Smoker**
☐ **Former Smoker**
☐ **Never Smoker**
☐ **Smoker Current Status Unknown**
☐**Unknown If Ever Smoked**

Recreational Drugs:
☐ **Never taken** ☐ **Name, if any: _____**

Please list each doctor (with address/fax) to send records to:
_____
_____
_____

Patient's Initials _____ Date: ___/___/____

REVIEW OF SYSTEMS

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less than optimal function. Mark the box next to the symptom you currently have. If you do not have any of the following symptoms on each category please mark I DENY any of the listed.

CONSTITUTIONAL

□ **I DENY** having any of the symptoms or problems listed below.
□ Fever
□ Chills
□ Fatigue
□ Weight loss
□ Weight Gain

EYES

□ **I DENY** having any of the symptoms or problems listed below.
□ Eye Redness
□ Vision loss
□ Dry eyes
□ Eyelid drooping

EARS / NOSE / THROAT

□ **I DENY** having any of the symptoms or problems listed below.
□ Dental problems
□ Difficulty/Loss of hearing
□ Ringing in the ears (tinnitus)
□ Attacks of dizziness (vertigo)
□ Nasal congestion
□ Sneezing
□ Sore throat
□ Snoring
□ Recent change in voice quality
□ Difficulty swallowing (dysphagia)
□ Nose bleeds (epistaxis)

HEART & CIRCULATION

□ **I DENY** having any of the symptoms or problems listed below.
□ Chest pressure (angina)
□ Palpitations, racing or pounding
□ "Black outs" (syncope)
□ Swelling of legs (edema)

RESPIRATORY

□ **I DENY** having any of the symptoms or problems listed below.
□ Asthma or wheezing
□ Cough
□ Coughing blood (hemoptysis)
□ Shortness of breath (dyspnea
□ Sleep apnea

STOMACH/INTESTINES

□ **I DENY** having any of the symptoms or problems listed below.□ Nausea
□ Poor appetite (anorexia)
□ Frequent heartburn
□ Bloody vomit (hematemesis)
□ Bloody stools (melena)
□ Diarrhea
□ Stool incontinence
□ Liver jaundice

ENDOCRINE/METABOLISM

□ **I DENY** having any of the symptoms or problems listed below.
□ Hyperthyroidism
□ Hypothyroidism
□ Unusual hair loss or growth
□ Goiter

KIDNEYS / URINARY TRACT

□ **I DENY** having any of the symptoms or problems listed below.
□ Kidney disease or failure
□ Pain or burning with urination
□ Dribbling or incontinence
□ Frequent Night Urination
□ Bladder infections
□ Blood in urine during past year

MUSCULOSKELETAL

□ **I DENY** having any of the symptoms or problems listed below.
□ Arthritis or other joint disease
□ Problem with walking
□ Muscle cramping

ALLERGY

□ **I DENY** having any of the symptoms or problems listed below.
□ Food intolerance
□ Itching

DERMATOLOGIC/SKIN

□ **I DENY** having any of the symptoms or problems listed below.
□ Rashes, psoriasis or dermatitis
□ New skin growth or mole

NEUROLOGIC

□ **I DENY** having any of the symptoms or problems listed below.
□ Headache
□ Epilepsy or seizures
□ Other nervous disorder

PSYCHIATRIC

□ **I DENY** having any of the symptoms or problems listed below.
□ Anxiety
□ Loss or change in appetite
□ Behavioral change
□ Auditory Hallucinations
□ Visual Hallucinations
□ Confusion
□ Depression
□ Memory loss
□ Mood change

HEMATOLOGIC/BLOOD

□ **I DENY** having any of the symptoms or problems listed below.
□ Bleeding or bruising tendency
□ Previous blood transfusion
□ Slow wound healing

MEN ONLY

□ **I DENY** having any of the symptoms or problems listed below.
□ Testicular swelling
□ Prostate Problems
□ Frequent urination

WOMEN ONLY

□ **I DENY** having any of the symptoms or problems listed below.
□ Painful periods
□ Excessive Flow
□ Irregular cycles
□ Vaginal Burning
□ Hot Flash

Are you pregnant? Yes or No