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MRN:

Patient Name:

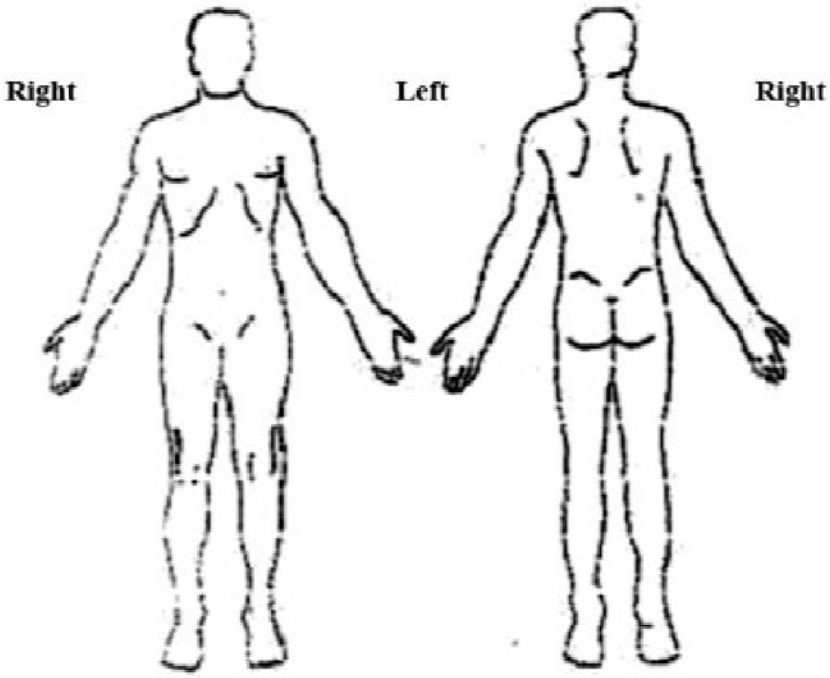
SPINE NEW PATIENT QUESTIONNAIRE

Department of Orthopedic Surgery

Please take the time to answer a few questions regarding your symptoms.

Pain Diagram

Please draw out your symptoms on the diagram below using the following symbols:



Numbness: 00000
Pins & Needles: ------
Stabbing: //////
Burning: xxxxx

History:

Chief complaint:_____

What is your dominant hand? ☐ Right ☐ Left Date of injury? _____

What is your current pain level? (Please check; 0: no pain, 10: worst pain imaginable)

☐ 0—☐ 1—☐ 2—☐ 3—☐ 4—☐ 5—☐ 6—☐ 7—☐ 8—☐ 9—☐ 10

When did your symptoms first start?_____

When did your symptoms get worse?_____

What is worse: ☐ your neck ☐ back pain ☐ your arm ☐ leg pain?

Is your pain: ☐ Constant ☐ Intermittent ☐ Occasional?

Is your pain: ☐ Getting better ☐ Getting worse ☐ Staying the same?

Is your pain worse: When first getting up from bed? ☐ No ☐ Yes

At the end of the day? ☐ No ☐ Yes

When changing positions? ☐ No ☐ Yes

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What makes your pain worse? (sitting, standing walking, lying down, bending forward, leaning back, etc) _____

What makes your pain better?

(sitting, standing walking, lying down, bending forward, leaning back, etc)

_____

Are you having any of the following difficulties? (Please check if applicable)

☐ Loss of bladder control
☐ Urgent desire to urinate
☐ Loss of bowel control
☐ Loss of sensation in genitalia and anal region
☐ Difficulty walking
☐ Limping
☐ Use of cane, crutch, or walker
☐ Use of wheelchair
☐ Problems with balance
☐ I have none of these

Do you have any weakness? ☐ Arms ☐ Hand ☐ Legs ☐ Feet

Do you have numbness or tingling? ☐ No ☐ Yes - Where? _____

Do you have headaches associated with your symptoms? ☐ No ☐ Yes

Are you having any difficulty handling small objects? (pins, coins, needles, buttons, etc) ☐ No ☐ Yes

Have you had a steroid injection in the past? ☐ No ☐ Yes

When?_____ Did the injection help? ☐ No ☐ Yes

Have you had physical therapy in the past? ☐ No ☐ Yes

When?_____ Did physical therapy help? ☐ No ☐ Yes

Any previous treatments for your symptoms? (Chiropractor, acupuncture, injections, previous surgery) _____

Any improvement? ☐ No ☐ Yes

What pain medicines are you using now?

_____

Any relief? ☐ No ☐ Yes

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Past Medical History (Please check NO or YES for any significant conditions)

Anemia	☐ No	☐ Yes	Heart Defect	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	Heart Attack	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Heart Failure	☐ No	☐ Yes
Alcohol dependency	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes
Arrhythmia	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes	Immune Disorder	☐ No	☐ Yes
Bleeding/Bruising	☐ No	☐ Yes	Intestinal Problems	☐ No	☐ Yes
Blood Disorder	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
COPD	☐ No	☐ Yes	Liver Disease	☐ No	☐ Yes
Chronic Bronchitis	☐ No	☐ Yes	Migraine/Headache	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes
Depression	☐ No	☐ Yes	Obesity	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Drug Abuse	☐ No	☐ Yes	Sinus problems	☐ No	☐ Yes
Epilepsy/Seizures	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes	Tuberculosis (TB)	☐ No	☐ Yes
Hay Fever	☐ No	☐ Yes	Stomach Ulcers	☐ No	☐ Yes

Other (Please list):

_____

Past Surgical History (Please list all surgeries and approximate dates)

_____

_____

_____

Medications (Please list name, dose, and frequency of all medications)

_____

_____

_____

_____

_____

Allergies (Please list all medication and latex allergies and describe reaction)

_____

_____

_____

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Social History

Do you smoke cigarettes? ☐ No ☐ Yes - Packs per day? _____

How many years? _____ If you quit, when? _____

Do you use any other forms of tobacco? ☐ No ☐ Yes

What type? _____

Do you drink alcohol? ☐ No ☐ Yes - How often and how much? _____

Do you use drugs other than prescribed or over the counter medications? ☐ No ☐ Yes

What do you use? _____

Birthplace? _____

Marital Status/Relationship? _____

Current Occupation: _____

Family History (Please list medical problems in your family)

	Age	Medical Problems	If deceased, cause of death
Father			
Mother			
Siblings			
Children			
Grandparent			

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SPINE NEW PATIENT QUESTIONNAIRE

Department of Orthopedic Surgery

Review of Systems – Please check all that are applicable. ☐ **None are applicable**

General	**Respiratory - continued**	**Male**
☐ Good health	☐ Wheezing	☐ Pain with sex
☐ Recent weight changes	☐ Painful breathing	☐ Hernia
☐ Fatigue	**Gastrointestinal**	☐ Penile discharge
☐ Recurrent fever or chills	☐ Swallowing difficulties	☐ Sores
☐ Headache	☐ Heartburn	☐ Masses or pain
Skin/Breast	☐ Change in appetite	☐ Erectile dysfunction
☐ Rashes	☐ Nausea	☐ STD's
☐ Lumps	☐ Change in bowel habits	**Female**
☐ Itching	☐ Rectal bleeding	☐ Pain with sex
☐ Color changes	☐ Constipation	☐ Vaginal dryness
☐ Hair and nail changes	☐ Diarrhea	☐ Hot flashes
☐ Pain	☐ Yellow eyes or skin	☐ Vaginal discharge
☐ Discharge	**Genitourinary**	☐ Itching or rash
Ear/Nose/Throat	☐ Frequency	☐ STD's
☐ Decreased hearing	☐ Urgency	**Neurologic**
☐ Ringing in ears	☐ Burning or pain	☐ Dizziness
☐ Pain	☐ Blood in urine	☐ Fainting
☐ Drainage	☐ Incontinence	☐ Seizures
☐ Stuffiness	☐ Change in urinary strength	☐ Weakness
☐ Discharge	**Musculoskeletal**	☐ Numbness
☐ Nosebleeds	☐ Muscle or joint pain	☐ Tingling
☐ Sinus pain	☐ Stiffness	☐ Tremor
☐ Dry mouth	☐ Back pain	**Hematologic**
☐ Sore throat	☐ Redness of joints	☐ Ease of bruising
☐ Hoarseness	☐ Swelling of joints	☐ Ease of bleeding
☐ Non-healing sores	☐ Trauma	**Endocrine**
☐ Bleeding	**Cardiovascular**	☐ Heat or cold intolerance
☐ Swollen glands	☐ Chest pain or discomfort	☐ Sweating
Vascular	☐ Tightness	☐ Frequent urination
☐ Calf pain	☐ Palpitations	☐ Excess thirst
☐ Leg cramping	☐ Shortness of breath with activity	☐ Change in appetite
☐ Varicose veins	☐ Difficulty breathing lying down	**Psychiatric**
Respiratory	☐ Swelling	☐ Nervousness
☐ Cough	☐ Sudden awakening from sleep with shortness of breath	☐ Depression
☐ Sputum		☐ Memory loss
☐ Coughing up blood		☐ Stress

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Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to patient: _____

Interpreter Signature _____ Date _____ Time _____

Interpreter ID # _____