SPINE HISTORY

DMOS ORTHOPAEDIC CENTERS

Date: _____

Name: _____ Date of Birth: _____

1. Why are you seeing the provider today? _____

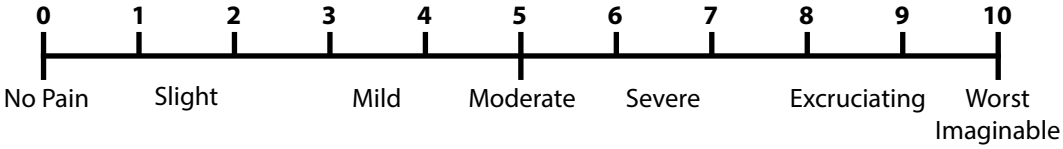
2. How long has pain/condition been present? _____

3. Has pain/condition worsened recently? ☐ No ☐ Yes, how recently? _____

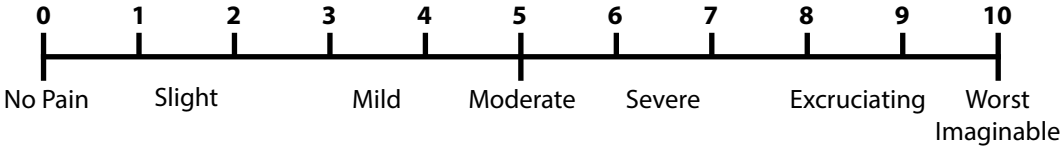
4. What started the pain/condition? _____

5. How do you rate your pain?

Back/Neck Pain



Arm/Leg Pain



6. Quality of the Pain: ☐ Sharp ☐ Burning ☐ Dull ☐ Aching ☐ Other:

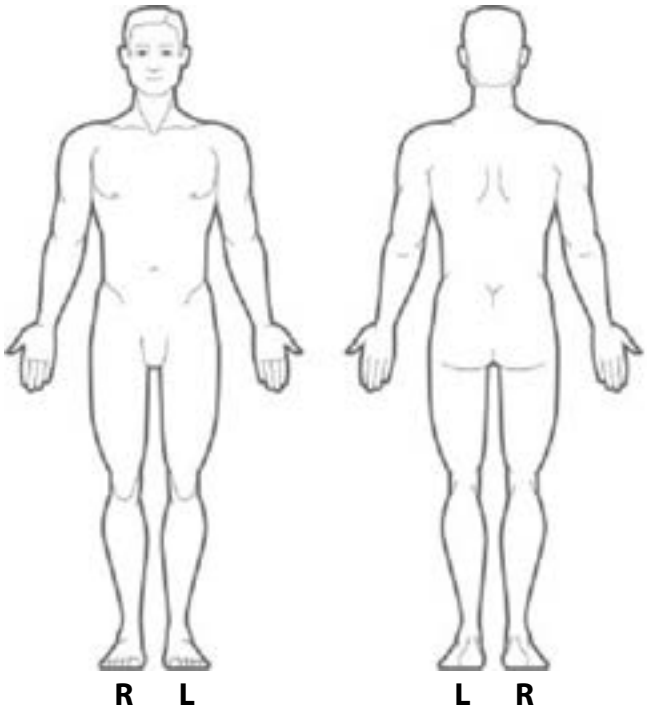
7. How much of your pain is in your Neck/Back or Arm/Leg? (Please give a percentage -- i.e. 50%)

Neck: _____ Arm and which side: _____

Back: _____ Leg and which side: _____

8. Location of the Pain/Condition:

Stabbing Pain	/////
Burning Pain	OOOOO
Aching Pain	XXXXX
Pins/Needles	VVVVV
Numbness	+++++



FOR OFFICE USE ONLY

HT: _____ WT: _____

BMI: _____ Temp: _____

9. What makes the pain/condition better? _____

10. What makes the pain/condition worse? _____

11. Is the pain/condition:

☐ Continuous ☐ Activity Related ☐ Night Pain ☐ Other: _____

12. Did the pain start at work? _____

• Have you filed a worker's compensation claim? _____

13. Have you ever lost bowel or bladder control? _____

14. Have you had spine surgery before? If so, what surgery? _____

• Did it help? _____

15. Treatments have included:

☐ No medications, therapy, manipulations/chiropractor, injections, or braces.

CHECK TREATMENT IF IT HELPED:

☐ Physical Therapy, exercise
☐ Massage or ultrasound
☐ Traction
☐ Chiropractor
☐ Tens Unit
☐ Anti-Inflammatory Medications
☐ Narcotic Medications
☐ Epidural Injections (how many?_____)
☐ Trigger Point Injections
☐ Other _____

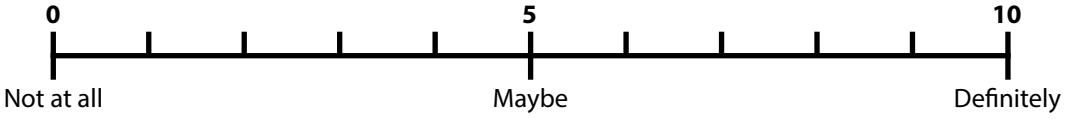
16. If you have seen other surgeons for this problem and were not happy, why?

☐ Did not answer my questions
☐ Personality Issues
☐ Had no suggestions on what to do
☐ Office Staff Issues
☐ Spent too little time with me
☐ Other _____

17. My main goal(s) today is (are) to get (check all that apply):

☐ Second opinion
☐ Recommendation for Physical Therapy
☐ Medications
☐ Injection Treatments
☐ Surgery
☐ Other_____

If recommended, please rate how interested you are in having **surgery** to treat your problem:



Primary Care Provider: _____ Referring Doctor: _____

Pharmacy name and location: _____

List medication you have taken for THIS problem:

MEDICATION	DOSE	FREQUENCY	TAKEN FOR

List ALL CURRENT medications:

MEDICATION	DOSE	FREQUENCY	TAKEN FOR
		ANTICOAGULANT/BLOOD THINNER	

Over the counter/herbal medications: _____

List all allergies: _____ Contrast Allergy: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No Hemoglobin A1c number: _____

SOCIAL HISTORY:

Work Status: ☐ Working ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

- Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children: ☐ No ☐ Yes, How Many? _____

Are you currently smoking? ☐ No ☐ Yes, How many packs/day? _____ For how many years? _____