Spine&Nerve DIAGNOSTIC CENTER

NAME: _____ **DATE:** _____

MEDICAL HEALTH QUESTIONNAIRE

PHYSICIAN USE ONLY
HEIGHT _____
WEIGHT _____
BP _____Pulse_____

If you are represented by an attorney for your workers compensation or personal injury case, who is your attorney?

_____

I. CURRENT INFORMATION:

1. What is the major problem leading to this visit?

2. If you had an injury, how were you injured and what was the date of your injury?

3. If you had an injury, have you ever had similar symptoms prior to the injury? If yes, were you ever treated by a medical provider for your symptoms?

4. What activities make your pain worse (please circle):

Sitting Standing Walking Bending Lifting Laying Down

5. What activities make you pain better (please circle):

Sitting Standing Walking Bending Lifting Laying Down

6. Please list all medications you are currently taking. Please list the drug, dosage, and how often you need to take it:

7. Please list any medications you are allergic to:

Are you allergic to Iodine? Yes / No

8. Please circle any of the follow imaging that have been done related to your problem:

X-RAYS, EMG, Bone Scan, CT, MRI

PREVIOUS TREATMENT:

9. What type of treatment have you had ***prior*** to your visit with our office today?

Please circle any medications that you have tried in the past:

NSAIDS	MUSCLE RELAXANTS	SLEEP AIDS
Aspirin (ASA)	Flexeril	Trazodone
Ibuprofen (Advil, Motrin)	Robaxin	Temezepam
Acetaminophen (Tylenol)	Soma	Lunesta
Naproxen	Skelaxin	Ambien
Celebrex	Baclofen	
Diclofenac	Zanaflex	
Nabumatone (Relafen)		

NERVE/MOOD STABILIZERS		
Lidocaine patch	Effexor	Seroquel
Gabapentin	Cymbalta	
Lyrica	Savella	
Topamax		
Amitriptyline		
Nortriptyline		

OPIOIDS	
Hydrocodone/acetaminophen (Norco)	Suboxone
Oxycodone/acetaminophen (Percocet)	
Fentanyl (Duragesic) Patch	
Morphine	
Oxycontin	
Methadone	
Butrans Patch	
Nucynta	

Please indicate what type of therapy you have had in the past:

	DATE:	NUMBER OF VISITS	HELPFUL Y/N
Physical Therapy			
Chiropractic Therapy			
Acupuncture			
Massage Therapy			
Pool Therapy			
Yoga/Stretching			
Meditation			
Functional Restoration Program			
Pain psychologist/ Cognitive Behavioral Therapy			
Ice pack			
Heat			
TENS unit			
H-wave			
Back brace			
SI (sacroiliac) joint belt			
Wrist brace			

Any other treatments (Bowen therapy, traction, prolotherapy, etc):

Please indicate what type of procedures you have had in the past:

Circle if applicable:		DATE:	NUMBER OF VISITS	HELPFUL Y/N
Epidural steroid injections	**(neck) (low back)**			
Facet joint injections	**(neck) (low back)**			
Radiofrequency ablation	**(neck) (low back)**			
Injections of the:	**(knee) (shoulder) (ankle)**			
SI (sacroiliac) joint injections				
Trigger point injections	**(neck) (low back)**			
Previous surgery---neck or back				
Spinal cord stimulation	**(neck) (low back)**			

Have you seen a Surgeon in the past for your symptoms? (please circle)

Yes No

II. PAST HISTORY:

1. Please list all past surgeries and all past hospitalizations. Please include the year for each.

2. Please circle any of the following that you have had in the past:

MENINGITIS, ENCEPHALITIS, POLIO, FAINTING, CONVULSIONS, EPILEPSY, HEAD INJURY, UNCONSCIOUSNESS, DIABETES, TUBERCULOSIS, LUNG DISEASE, HIGH BLOOD PRESSURE, HEART DISEASE, STOMACH DISEASE, LIVER DISEASE, KIDNEY DISEASE, NECK TROUBLE, BACK TROUBLE, A STROKE, CANCER, VENEREAL DISEASE, HEPATITIS, HIV, AIDS. OTHER:

III. SOCIAL HISTORY:

1. Please circle all of the following that apply to you:

MARRIED DIVORCED SINGLE WIDOW

EMPLOYED UNEMPLOYED RETIRED DISABLED

2. Where were you born?

3. What is your highest level of education?

4. Do you drink alcoholic beverages (wine, beer, cocktails)?
   If so, how often, how much, and for how long?

5. Do you currently use tobacco? Yes: ___ No: ____

   If yes: How long? _____ How much? _____

   What form of tobacco do you use? _____

   If you have previously used tobacco and quit, when did you quit? _____

   How much, and in what form were you using? _____

6. Do you have any history of drug use or drug abuse?
   Please explain.

7. Have you ever been discharged from another medical practice because of medication noncompliance or urine toxicology result? If Yes, please explain:

IV. EMPLOYMENT HISTORY:

1. Are you currently employed?

2. What is your job title?

3. How long have you been employed at this job?

4. If you are not currently working:

   What was your last job? _____

   When did the job end? _____

   Why did the job end? _____

   How long were you employed there? _____

5. Please list past jobs, and the length of time employed at each:

6. Please list your activities of interest:

IV. FAMILY HISTORY:

1. Are there any diseases that run in your family? If yes, please list:

2. Is there a history of back or neck problems in your family?
   If so who?

IMMEDIATE FAMILY HISTORY

	AGE, OR AGE AT DEATH	CAUSE OF DEATH	HEALTH	MAJOR DISEASES
FATHER				
MOTHER				
BROTHERS				
SISTERS				
CHILDREN				

V. REVIEW OF SYSTEMS (Please circle appropriate answer):

Do you have problems with:

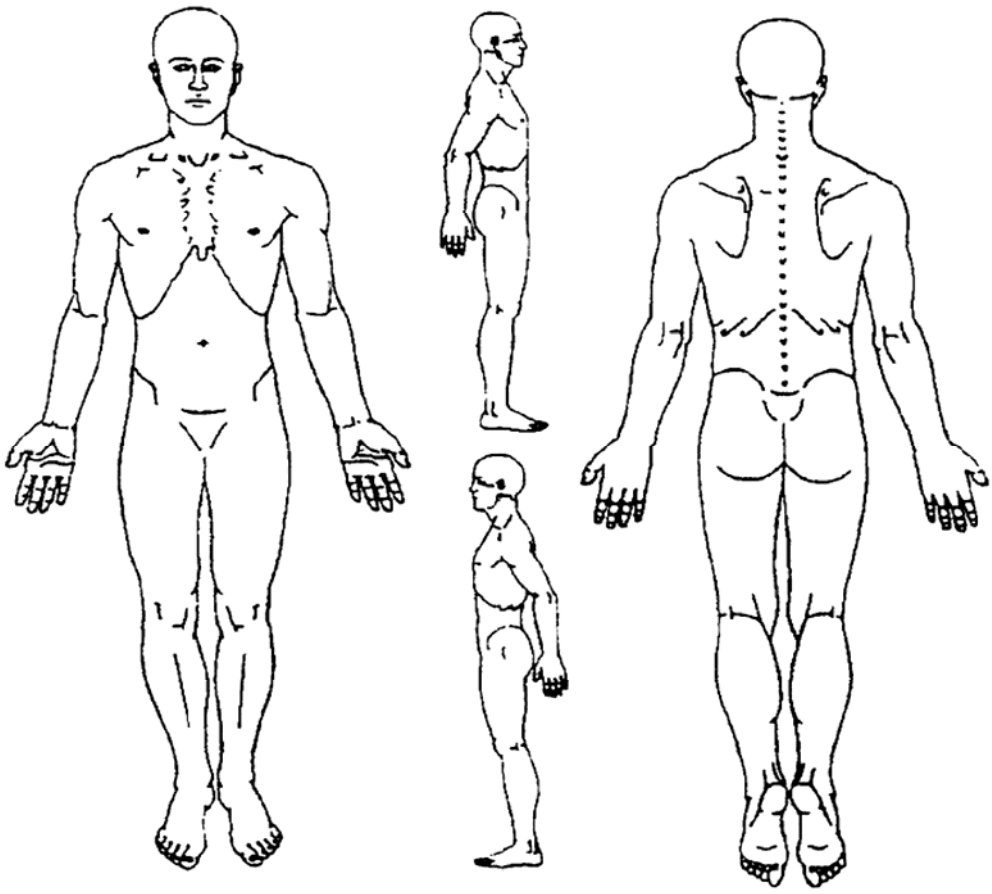
Cardiovascular	Chest Pain	Rapid Heartbeat	Leg/Ankle Swelling		Irregular Heartbeat
Constitutional	Weight Loss/Weight gain		Fever	Chills	Night Sweats
Eyes	Blurry Vision	Eye Pain	Eye Discharge	Dry Eyes	Decreased Vision
Gastrointestinal	Nausea/Vomiting	Stool Incontinence		Blood in stool/black stool	
Genitourinary	Bladder Incontinence		Urinary Tract Infections	Trouble Urinating	
Musculoskeletal	Joint Pain	Muscle Pain	Joint Swelling	Muscle Weakness	Muscle Spasm Stiffness
Neurological	Migraines	Numbness	Dizziness	Headaches	Loss of Balance
Psychological	Depression	Anxiety	Insomnia		
Respiratory	Short of Breath	Cough	Wheezing	Pain with Breathing	
Skin	Rash	Sores	Itching	Easily bruises	Easily scars

VI. PAIN DIAGRAM

Please mark you areas of pain:

Use the following descriptors to describe the quality of your pain:

Aching **^^^^** Numbness **oooo** Pins and Needles **....** Burning **xxxx** Stabbing ////



Please number and mark the severity of pain you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

PAIN LEVEL WITHOUT MEDICATIONS :

0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL WITH MEDICATIONS :

0 1 2 3 4 5 6 7 8 9 10