evival Spine Surgery Patient Questionnaire

Today's DATE:_____

Patient NAME:_____
Patient Date of Birth: _____
Family Doctor:_____
Reason for this Visit:

_____

_____

WHEN did your problem start:

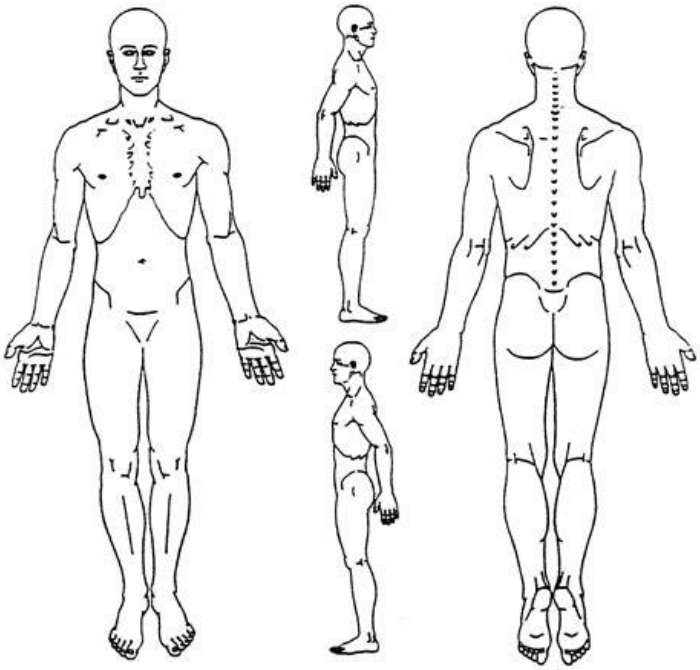
_____

HOW did your problem start:

_____

Your **PAIN DRAWING /DIAGRAM**:
Mark the areas where you feel the sensation:

********** aching
oooooooooo pins / needles / numbness
xxxxxxxxxx burning
////////////////// stabbing

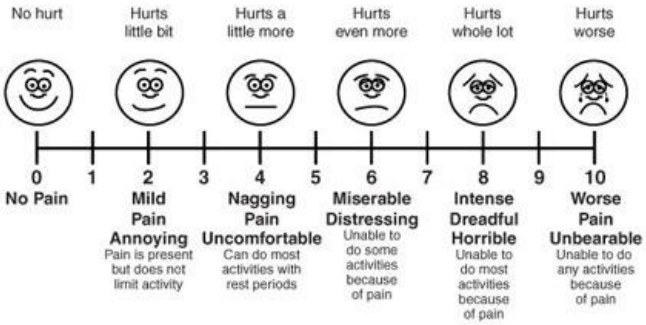


How bad does your pain

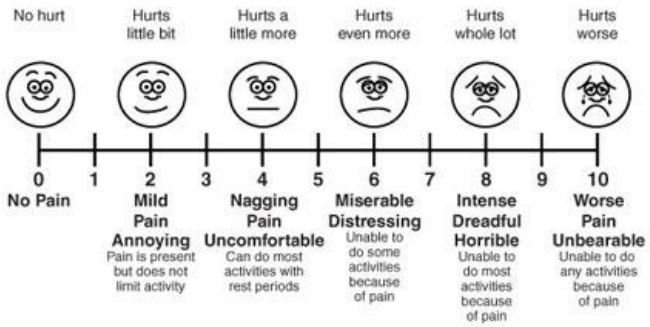
	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Burning				
Aching				
Exhausting				
Sickening				
Fearful				
Punishing				
Cruel				

How bad does your pain ***EVER GET:***

NOW:



Please describe your pain:



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DOB: _____

What makes your pain ***WORSE OR BETTER***?

	Worse	No Change	Better
Sitting			
Standing			
Walking			
Bending			
Lying Down			
Rest			
Coughing			
Neck Position			
Arm Position			

Which treatments have you used for current problem?

	Improved	Not Helpful
Physical Therapy		
Chiropractic		
Acupuncture		
Pain Clinic		
Spine Injections		
Spine Surgery		

Past health problems: **PLEASE LIST PROBLEMS IN THE APPROPRIATE AREAS**:

Head/Brain
Eyes
Ears, Nose, Throat
Heart
Lungs
Stomach, Abdomen, Bowels
Liver
Kidney, Bladder
Prostate or Sexual Organs
Bones, Muscles, Joints
Breasts
Mental Problems
Cancer
Other

Review of Systems: **PLEASE CIRCLE IF ANY PERTAIN (or cross out if n/a):**

Constitutional Symptoms: Fever, chills, fatigue or weight loss/gain of over 20 pounds
Ear/Nose/Throat: Hearing loss, sinusitis, hoarseness or vertigo
Eyes: Double vision, blurring or glasses
Cardiovascular: Chest pain or palpitations
Respiratory: Shortness of breath, asthma or chronic cough
Stomach/Intestinal: Appetite loss, nausea, diarrhea, constipation, heartburn or abdominal pain
Urinary: Hesitancy, incontinence or burning urination
Skin/Breast: Rashes, lesions or scars
Neurological: Speech/swallowing problems, stroke, seizure or headaches
Psychological: Depression, hallucinations, sleep disturbances, alcoholism or drug addiction
Hormonal: Growth/hair changes, excess thirst or decreased energy
Hematological/Blood: Easy bruising, blood clots, bleeding disorders, anemia or swelling
Allergies: Food allergies, immune deficiency or frequent infections

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Past Surgeries: (Please list each separately):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies to **Medications:**

1. _____
2. _____
3. _____
4. _____

Medications currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Social Questions:

Do you smoke: YES_____ NO_____
If yes, how many packs per day: _____
How many years smoking? _____
Do you consume alcohol: YES_____ NO_____ How Often:_____
Have you ever used drugs: YES_____ NO_____
If yes, please list the drugs: _____
_____

Occupation Questions:

Are you currently working: _____
Your current job position: _____
What do you physically do at your job (ie: lift boxes): _____
_____
Your employer: _____
Have you lost time from your job due to the current problems? YES_____ NO_____

For Patients 65 years and older:

Falls in the last year? Yes or No (circle answer). Number of falls: _____
Did the fall(s) result in injury? Yes or No (circle answer). Details: _____
Do you use an assist device (i.e. walker, cane, wheelchair)? _____
Have you ever received a Pneumococcal (pneumonia) vaccine? If so, what month/year? _____

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PLEASE CHECK THE APPROPRIATE BOX(ES):

Relationship to Patient:	**Father**	**Mother**	**Brother**	**Sister**	**Daughter**	**Son**	**Adopted**
Alive and Well							
Deceased							
Heart Disease							
Diabetes							
High Blood Pressure							
Stroke							
High Cholesterol							
Cancer (Type)							
Thyroid Issue							
Respiratory Disease							
Depression							
Osteoporosis							
Asthma							
Kidney Disease							

Office Use Only
Reviewed with patient by: _____ Date: _____