EAST COAST ORTHOPAEDICS

SPINE HISTORY FORM

Patient Name: ____ Date of Birth: __________________

Age: _________ Sex: ○ M ○ F Height: __________ Weight: __________ ○ Right Handed ○ Left Handed

Race: ○ Caucasian ○ African American ○ Asian ○ Hispanic ○ Other _____________

Ethnicity: ○ Non-Hispanic ○ Hispanic ○ Unknown ○ Declined to Answer

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other: __________________________

Pharmacy: _____________________ Location: ________________________ Phone #__________________

Primary Care Physician: ________________________ Referring Physican____________________________

PROBLEM YOU ARE BEING SEEN FOR TODAY:

○ Neck Pain Arm pain ○ R ○ L Arm numbness ○ R ○ L

○ Low Back Pain Leg pain ○ R ○ L Leg numbness ○ R ○ L

○ Difficulty Walking

HAVE YOU EVER HAD A PROBLEM LIKE THIS IN THE PAST? ○ Y ○ N

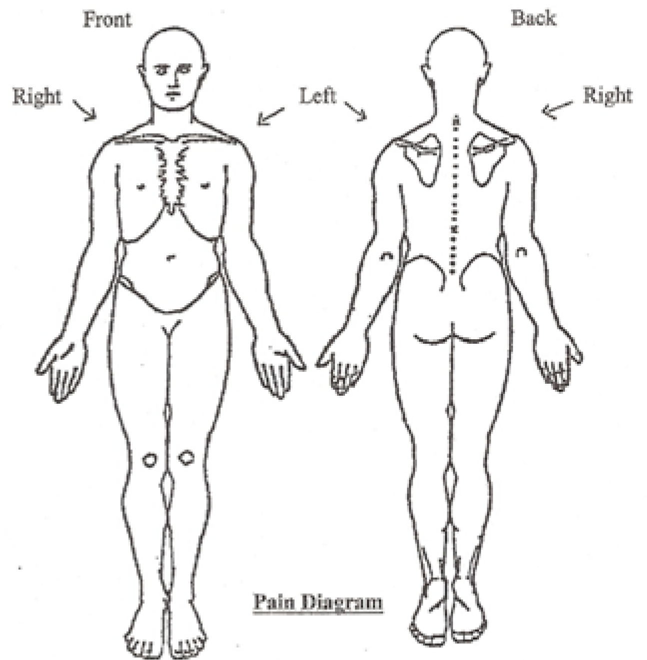
BRIEFLY DESCRIBE WHAT CAUSED YOUR SYMPTOMS: ____

____

____

YOUR PAIN IS BEST DESCRIBED AS:

○ Dull ache ○ Sharp ○ Burning ○ Electric Shock



ONSET OF Symptoms:

Please describe the onset of symptoms. Choose ONE item below:

○ No Injury-Gradual Onset Symptoms began:

#of____ ○ days ○ weeks ○ months ○ years ago

○ Work Injury on _________ (injury date)

○ Motor Vehicle Accident on _________ (injury date)

○ Other Injury on______________(injury date)

WHERE IS YOUR PAIN NOW? (Use the diagram to the right)

Place an X in the area(s) you feel the most pain

Place an O on the body diagram where you feel numbness/tingling

SEVERITY OF PAIN: With 10 being the worst

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

TIMING OF PAIN: ○ Occasionally ○ Intermittantly

○ Nearly Constant ○ Constantly

RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain (please select one for each item)

Lying Down	○ Improves Pain	○ No Change	○ Worsens Pain
Standing	○ Improves Pain	○ No Change	○ Worsens Pain
Sitting	○ Improves Pain	○ No Change	○ Worsens Pain
Walking	○ Improves Pain	○ No Change	○ Worsens Pain
Exercise	○ Improves Pain	○ No Change	○ Worsens Pain
Coughing/Sneezing	○ Improves Pain	○ No Change	○ Worsens Pain
Bowel Movements	○ Improves Pain	○ No Change	○ Worsens Pain

Have you had any recent change in bowel or bladder habits?

○ Y ○ N Describe: ____

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Patient Name: ____

Do you experience any of the following?: ○ Clumsiness in your hands ○ Difficulty with buttons ○ Changes in handwriting ○ Changes in the way you walk ○ Unsteadiness

ACTIVITIES AND YOUR PAIN

How many blocks can you walk? ○ 1-2 blocks ○ 2-5 blocks ○ 5-10 blocks ○ Greater than 10 blocks

To assist walking I use a ○ Cane ○ Walker ○ Wheelchair ○ No assistance device

How long can you stand? ○ 5 minutes ○ 10 minutes ○ 30 minutes ○ 1 hour ○ 1 hour +

How often during the day do you lie down because of pain? ○ Never ○ Seldom ○ Sometimes ○ Often ○ Constantly

I am NOT able to perform the following activities of daily living (select all that apply) ○ Doing yard work or shopping ○ Performing household chores ○ Going to work ○ Socializing with friends ○ Participating in recreational activities ○ Exercising

TREATMENTS FOR YOUR SPINE: (select all that apply) ○ Physical Therapy ○ Tens Unit ○ Facet Blocks ○ Injections ○ Epidural Steroid Injections ○ Chiropractor ○ Medications ○ Spine Surgeries ○ Activity Modification

LENGTH OF PRIOR TREATMENT: ○ 0-3 months ○ 3-6 months ○ 6-12 months

DATE OF SPINE SURGERY TYPE OF OPERATION HOSPITAL

____
____
____

PAST MEDICAL HISTORY

Surgical History

○ Appendectomy	○ D&C	○ Neck Surgery
○ Arthroscopy	○ Gallbladder Surgery	○ Pacemaker
○ Back Surgery (specify above)	○ Heart Bypass	○ Prostate Surgery
○ Breast Surgery	○ Heart Valve Replacement	○ Skin Cancer
○ Cataract Surgery	○ Hernia Repair	○ Tonsillectomy
○ Carpal Tunnel	○ Hysterectomy	
○ Cesarean Section	○ Kidney Surgery	
○ Joint Replacement (which body part):____ ____________________________		
○ Other Surgeries: ____		

Current Medications :

○ None	Medication	Dosage
	_____________________________________	_____________________________________
	_____________________________________	_____________________________________
	_____________________________________	_____________________________________
	_____________________________________	_____________________________________
	_____________________________________	_____________________________________
	_ ___________________________________	_____________________________________

Allergies (not seasonal) ○ No known Allergies
○ Penicillin ○ Aspirin ○ Codeine ○ Tylenol ○ Iodine ○ Sulfur ○ Shellfish ○ Latex Allergy ○ Adhesive Tape
○ Other: ____

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Patient Name: ____

PAST MEDICAL HISTORY

Have you been diagnosed with any of the following? ○ NONE			
○ Alcoholism	○ COPD	○ High Cholesterol	○ Neurological Disorders
○ Arthritis	○ Diabetes Type: _____________		○ Osteoporosis
○ Anemia	○ GERD		○ Pacemaker
○ Blood Clots	○ GI Disorders		○ Renal Disease
○ Blood Transfusion	○ Heart Disease - Specify________________		○ Rheumatoid Arthritis
○ Bronchitis	○ Hepatitis Type: __________	○ HIV/ AIDS	○ Stroke
○ Cancer	○ Hernia	○ Kidney Disease	○ Thyroid Disease
○ Other: _____________________	○ High Blood Pressure	○ Liver Disease	
Are you pregnant? ○ Y ○ N	Are you claustrophobic? ○ Y ○ N		

REVIEW OF SYSTEMS

HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS?					NONE	COMMENTS
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_________________
2) ENDO	○ Thyroid Disease	○ Heat or Cold Intolerance			○	_________________
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_________________
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_________________
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_________________
6) CV	○ Chest Pain	○ Palpitations			○	_________________
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_________________
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_________________
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_________________
10) NEU	○ Headaches	○ Dizziness	○ Seizures	○ Numbness	○	_________________
11) PSY	○ Depression / Anxiety	○ Drug / Alcohol Addic-tion	○ Sleep Disorder		○	_________________
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_________________

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?						
FATHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis

SOCIAL HISTORY

Smoking Status: ○Current every day smoker: # ____packs ○Occasional smoker #_____ packs

○ Previous Smoker ○ Never Smoker

Alcohol use? ○ None ○ Social ○ Frequent

Marital History: ○ Married ○ Single ○ Divorced ○ Widowed

Are you currently working? ○ Y ○ N ○ Retired ○ Disabled

Occupation: __________________________ Employer: ______________________ ○ Student

____ ___________

Signature Date

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