SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

SPINE INSTITUTE OF CENTRAL FLORIDA FIRST VISIT QUESTIONNAIRE

PATIENT NAME:______________________ **TODAYS DATE:** ________ **DOB:**________ **AGE:**________ **HANDEDNESS:** RIGHT/LEFT/AMBIDEXTROUS

ALLERGIES:______________________________ **OCCUPATION:**______________________ **PRIMARY CARE PHYSICIAN (NAME):** ____________________

Best Contact #: ( ) ______________________________

E-mail:______________________________________

CHIEF COMPLAINT (What brings you here today?):

____

____

____

Please List all LOCATIONS of Your Pain: ____________________

____

TYPE OF PAIN (Circle all that apply):

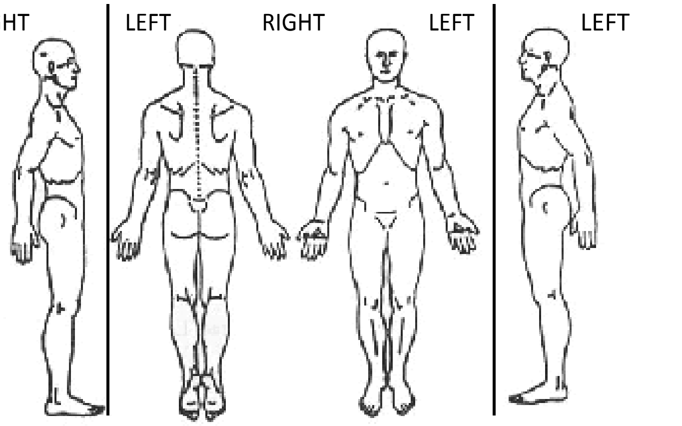
Weakness Burning Electricity Dull Ache
Numbness Stabbing Tingling Persisting Pins & Needles

Date of onset of symptoms: ______________________

How long symptoms have been present:____________________

DRAW AN "X" TO MARK THE LOCATION OF YOUR PAIN/SYMPTOMS

RIGHT LEFT RIGHT LEFT LEFT



How bad is your Pain? (Circle the number)

0 1 2 3 4 5 6 7 8 9 10

CIRCLE ALL PREVIOUS TREATMENTS

Nonsteroidal anti-inflammatory drugs (NSAIDS)

Ibuprofen	Lyrica, Neurontin	Physical Therapy	Cervical Spine Injections
Aleve	Pain medications	Chiropractor	Thoracic Spine Injection
Naproxen	Muscle Relaxers	Brace	Lumbar Spine Injection
Motrin		Home Exercises	Epidural Injection
Celebrex		Acupuncture	Facet Injections
Mobic			Nerve Ablation
			Spine Surgery

List other treatments: ______________________________

ORTHOPAEDIC INJURY

WAS AN AUTOMOBILE INVOLVED? Yes No
WAS INJURY WORK RELATED? Yes No
LITIGATION PENDING? Yes No

Describe Injury or condition : ______________________________

____

____

____

Since the pain began/condition began it (Circle all that apply):

Improved Comes & Goes Worsened Stayed the same

What AGGRAVATES the pain? (Circle all that apply):

Walking Sitting Stooping/Bending Nothing in Particular
Standing Lying Down Activity in General

Other/comments:______________________________

What makes the pain BETTER? (Circle all that apply):

Walking Standing Heat or Cold Compress
Sitting Lying Down Nothing in particular

Other/Comments: ______________________________

Are you experiencing any of the following (Circle all that apply):

Hand clumsiness Changes in handwritting
Dropping things Difficulty opening jars
Dexterity changes Off balance when walking

Symptoms interfere with SLEEP? Never Occasionally Frequently

Have you had a previous NECK problem? Yes No

Have you had a previous BACK problem? Yes No

Difficulty WALKING relating to presenting symptoms? Yes No

Do you use any ASSISTIVE DEVICE(s) for ambulation? Yes No
(e.g. Wheelchair, walker, cane, crutches, scooter, etc.)
If yes, which assistive device do you use? ____________________

Please CIRCLE if you now have or have had recently any of the following:

MUSCULOSKELETAL:
Painful joints
Cramps
Joint stiffness

HEMATOLOGIC:
Unusual bleeding
Easy bruising

RESPIRATORY:
Shortness of breath
Persistent Cough
Blood in sputum

CARDIAC:
Chest pain
Heart attack
Irregular heart beat

GENITOURINARY:
Difficulty Urinating
Incontinence
Recurrent bladder infections
Changes in bowel or bladder function

ENDOCRINE:
Excessive thirst
Excessive urination
Hot flashes

GASTROINTESTINAL:
Diarrhea
Stomach pain
Constipation
Vomiting
Blood in stools
Tarry stools

GENERAL:
Fever
Weight loss
Excessive tiredness

THROAT:
Swallowing difficulty
Jaw pain on chewing

NEUROLOGICAL:
Frequent headaches
Paralysis on one side
Numbness on one side
Slurred speech
Double vision
Loss of Consciousness
Incoordination

OTHER:
Hallucinations,
Loss of Energy
Panic attacks
Appetite changes
Depressed mood
Suicidal thoughts
Sleep disturbances
Homicidal thoughts
Difficulty concentrating
Agitation or sluggishness
Diminished interest in activities
Feeling of Guilt/Worthlessness

EYE:
Blindness
Cataract
Glaucoma
Sudden vision loss in 1 eye

EARS:
Hearing loss
Vertigo
Recurrent ear infections

ALLERGIC:
Red eyes
Hives
Nasal congestion

SKIN: Rashes

CURRENT MEDICATIONS:

Medication | Dosage | # of times taken a day

Do you take Aspirin or Blood Thinners? Yes No
(List medication on lines above)

SURGICAL HISTORY:

List all prior **SPINE** surgeries:

Procedure	Date	Surgeon	Place

List all other **NON SPINE** surgeries:

Procedure	Date

PAST MEDICAL HISTORY- DO YOU OR DID YOU HAVE:

Yes	No	High Blood Pressure
Yes	No	Diabetes
Yes	No	Heart Disease (Murmurs, Attacks)
Yes	No	Stroke
Yes	No	Migraine Headaches
Yes	No	Irritable Bowel Syndrome
Yes	No	Chest Pain
Yes	No	Cancer
Yes	No	Lung Disease (Emphysema, Asthma)
Yes	No	Arthritis
Yes	No	Thyroid Problems
Yes	No	Kidney Disease
Yes	No	Gout
Yes	No	High Cholesterol
Yes	No	GERD
Yes	No	Stomach Ulcers
Yes	No	Seizures (Epilepsy)
Yes	No	HIV/AIDS
Yes	No	Pneumonia
Yes	No	Rheumatic Fever
Yes	No	Venereal Disease
Yes	No	Colon Polyps
Yes	No	Hepatitis
Yes	No	Gall Bladder Disease
Yes	No	Prostate Problems
Yes	No	Sexual/ Menstrual Dysfunction
Yes	No	Depression, Anxiety
Yes	No	Anemia/Bleeding Problems
Yes	No	Liver Disease

List Any Other Medical Problems: ____________________

List Any Implants/Stents/Medical devices:____________________
(Please provide a copy of the implant ID card to check-in staff)

Name Of Pharmacy:____________________
Phone # :__________City: __________
Fax #:__________

FAMILY HISTORY: Do you have a family history of the following?
(Circle all that apply):

Back Problems | Stroke | Rheumatoid Arthritis | Neck Problems | Cancer | High Blood Pressure | Heart Disease | Diabetes | Osteoarthritis | Scoliosis | Other: __________

SOCIAL HISTORY (Circle all that apply):

Smoke: Yes No ___ Packs Per Day For____ years No, Quit in _______ Never A Smoker

Alcohol: Yes No Drink: Socially Moderately Heavily Occasionally Rarely Amount Per Week: __________

Illicit/Recreational Drugs: None Marijuana Cocaine Heroin PCP Meth Others (list): __________

Do you take any pain medications NOT prescribed to you? Yes No If Yes, list all: __________

Marital Status: __________ **How Many Children:** __________

REFERRAL SOURCE (Circle all that apply):

Primary Care Doctor | Another Patient | Online/Internet
Insurance Company | Self-Referral | TV/Magazine
Hospital (Name):__________ | Other Advertisement
Other Physician (Name): __________
Other (Please explain):__________

WORK STATUS (Circle one):

Employed Yes No Employer: __________

If no, out of work since what date: __________

Reason for unemployment: __________

Please use back page for additional writing space.