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?)

Describe your condition:_____

Please List all LOCATIONS of Your Pain: _____

TYPE OF PAIN (Circle all that apply):

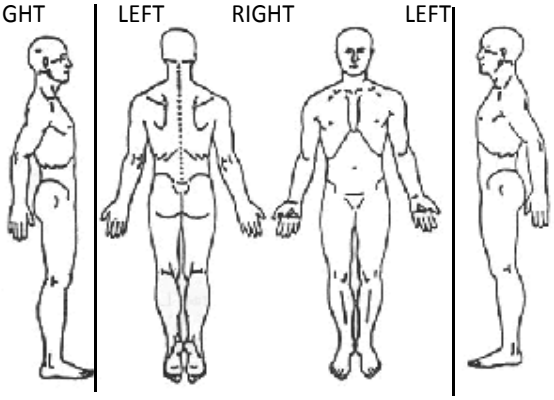
Weakness Burning Electricity Dull Ache
Numbness Stabbing Tingling Persisting Pins & Needles

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

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
Sleep disturbances
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

Suicidal Thoughts- Y / N
Homicidal Thoughts -Y / N

CIRCLE ALL PREVIOUS TREATMENTS

Nonsteroidal anti-inflammatory drugs (NSAIDS)
Ibuprofen
Aleve
Naproxen
Motrin
Celebrex
Mobic

Lyrica, Neurontin
Pain medications
Muscle Relaxers

Physical Therapy
Chiropractor
Brace
Home Exercises
Acupuncture

Cervical Spine Injections
Thoracic Spine Injection
Lumbar Spine Injection
Epidural Injection
Facet Injections
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?_____

*****STAFF USE ONLY*****

S.I. / H.I Verified : YES ☐ NO ☐

PATIENT NAME:_____ **TODAYS DATE:** _____ **DOB:**_____ **AGE:**_____

CURRENT MEDICATIONS:

Medication	Dosage	# of times taken a day

Do you take Aspirin or Blood Thinners? Yes No

If Yes circle one: **Preventative** OR **Prescribed**

If Prescribed list provider: _____

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

Rheumatoid Arthritis	Back Problems	Stroke
High Blood Pressure	Neck Problems	Cancer
Osteoarthritis	Heart Disease	Diabetes
	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
Insurance Company
Hospital (Name):_____
Other Physician (Name): _____
Other (Please explain):_____
Another Patient
Self-Referral
Online/Internet
TV/Magazine
Other Advertisement

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.