Neurosurgery Personal Health History

(Please fill out pages 1 through 12 **prior to arrival** in clinic)

Patient Name:_____ Date of Birth: _____/_____/_____

Date:_____/_____/_____

Age_____ Sex_____ Dominant Hand: ❑ Right ❑ Left ❑ Ambidextrous

Referring Provider: Name:	Address:	Phone:
Primary Care Provider: Name:	Address:	Phone:
Legal Next of Kin: Name:	Address:	Phone:

Clinical Information. DO NOT WRITE IN THIS SECTION	Height:	Weight:
Pulse:	BP:	RR:

What is your chief complaint? _____

Onset

When did this set of **CURRENT** problems begin?_____

What event(s) caused your current spine problem? (Check all that apply)

☐ Gradual onset	☐ Reaching	☐ Lifting	☐ Donôt know
☐ Fall	☐ Twisting	☐ Pushing	☐ Woke up with it
☐ Direct blow	☐ Bending	☐ Pulling	☐ Other_____

What were the circumstances surrounding this onset? (Check all that apply)

☐ Vehicle/Boating accident	☐ Recreational sport	☐ Repetitive injury
☐ On the job injury	☐ Non-work related incident	☐ No known cause

☐ Other_____

Please explain these events that surrounded the onset of this spine problem:

_____

_____

_____

_____

_____

_____

Do you feel your employer or another person caused this spine problem? ☐ Yes ☐No
If so please explain:_____
_____

Prior Spine Problems

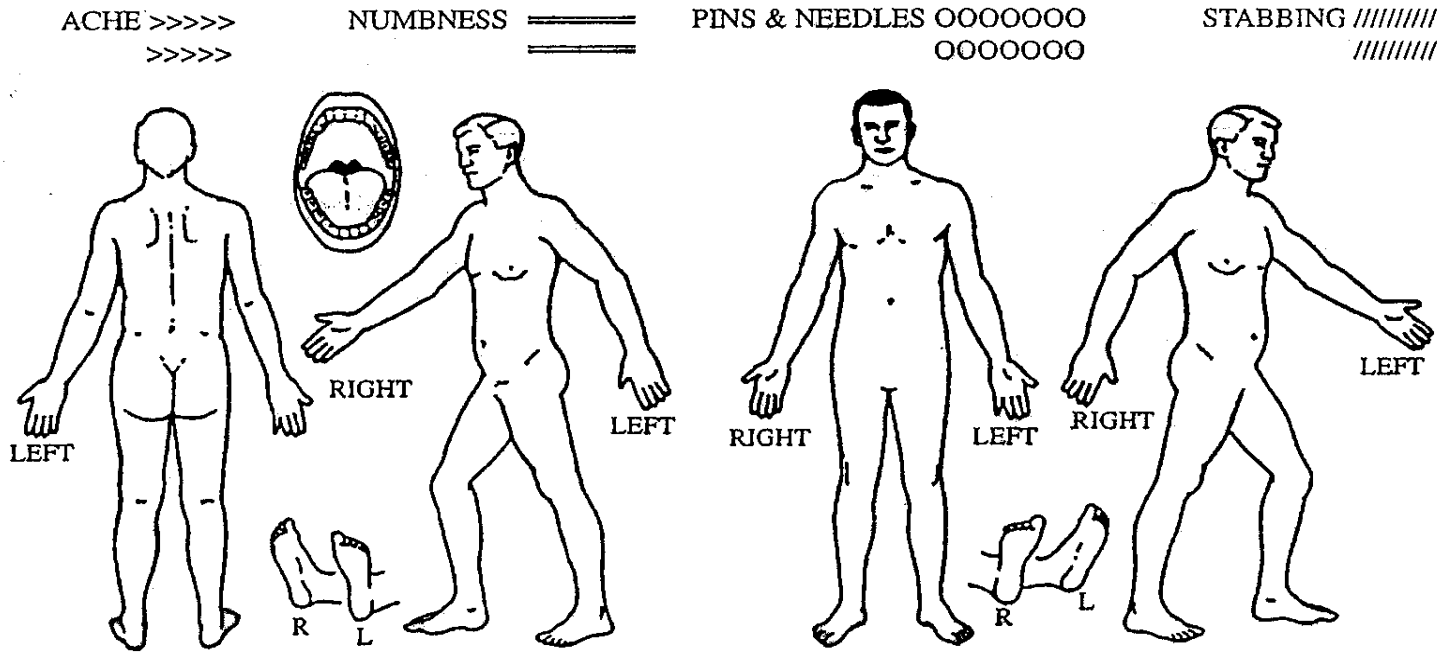
Prior to this current set of spine problems, have you had prior issues regarding **THIS CURRENT AREA** of your spine? ☐ Yes ☐No
Approximately when did these problems begin? _____
What were the circumstances surrounding the onset of these problems?

_____
_____
_____

How many prior surgeries have you had in the area of the spine that is being addressed today? _____
Have your current spine problems been on-going since they first started ☐ Yes ☐ No

Current Status

Mark the area on your body where you feel your **typical** pain. Include all affected areas. Use the appropriate symbols indicated below



Pain Severity

1. **If 10 is the worst pain imaginable, and 0 is no pain, please note your pain over the last TWO WEEKS:**

a) Please range your WORST pain.	0	1	2	3	4	5	6	7	8	9	10
b) Please rate your LEAST pain.	0	1	2	3	4	5	6	7	8	9	10
c) Please rate your overall or AVERAGE pain.	0	1	2	3	4	5	6	7	8	9	10

2. **In the last week, how many days did you have your usual pain?** 0 1 2 3 4 5 6 7

Patient Name:_____ Date of Birth: _____/_____/_____

3. In the last week, during your waking hours, about what percentage of the day were you in pain

☐Less than 10% ☐ 10 ï 59 % ☐ 50 ï 75% ☐75 ï 100%

☐ It also bothers me at night

4. Lumbar[Low Back/Leg(s)] **Patients-Do you have both low back and leg pain? ☐Yes ☐No**
If yes, please answer the following questions (a,b, and c):

a) Which is worse, your back pain or your leg pain? ☐Back pain ☐Leg pain ☐ About equal

b) Do you often have just back pain without leg pain? ☐Yes ☐No

c) Do you often have just leg pain without back pain? ☐Yes ☐No

5. Cervical[Neck/Arm(s)] **Patients-Do you have both neck and arm pain? ☐ Yes ☐ No**
If yes, please answer the following questions (a,b, and c):

a) Which is worse, your neck pain or your arm pain? ☐Neck pain ☐Arm pain ☐About equal

b) Do you often have just neck pain without arm pain? ☐Yes ☐No

c) Do you often have just arm pain without neck pain? ☐Yes ☐No

6. Check the worst and best times for your pain:

Worst	**Best**	**If you have NIGHT pain, does it:**
☐ First awakening	☐First awakening	☐Prevent you from falling asleep?
☐ Morning	☐ Morning	☐Awaken you at night?
☐ Afternoon	☐ Afternoon	☐Hurt worse when lying down at night
☐ Evening	☐ Evening	than during the day?
☐ Nighttime	☐Nighttime	

7. What does each of the following activities do to your pain?

	No Change	**Relieves Pain**	**Increases Pain**
Sitting	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Lying Down	_____	_____	_____
Bending forward	_____	_____	_____
Bending Backward	_____	_____	_____
Lifting	_____	_____	_____
Coughing / Sneezing	_____	_____	_____
Looking up	_____	_____	_____
Looking down	_____	_____	_____

8. What do you do to relieve your pain?

1) _____

2) _____

3) _____

4) _____

Progression:

1. **How is your <u>current</u> pain, compared to when this pain episode first started?**
   ☐Much improved ☐Somewhat improved ☐No change ☐A little worse ☐Much worse ☐N/A
2. **How much <u>change</u> do you expect in your pain <u>6 months from now</u>?**
   ☐Worse ☐No change ☐Some improvement ☐Marked improvement ☐Total relief

Bladder Function

If you have had any change in your bladder function, do you:

☐ Urinate more often
☐Have loss of control or accidents
☐Have a sense of urgency
☐Have a loss of sensation around groin or buttocks
☐Have problems with sexual function
☐Have had no change

Function:

1. **Pain intensity** (mark only one)
   ☐I can tolerate the pain I have without having to use pain killers
   ☐The pain is bad but I manage without taking pain killers
   ☐Pain killers give complete relief from pain
   ☐Pain killers give moderate relief from pain
   ☐Pain killers give very little relief from pain
   ☐Pain killers have no effect on the pain, I do not use them

2. **Personal Care (washing, dressing, etc.)** (mark only one)
   ☐I can look after myself normally without it causing extra pain.
   ☐I can look after myself normally but it causes extra pain
   ☐It is painful to look after myself and I am slow and careful
   ☐I need some help but manage most of my personal care
   ☐I need some help everyday in most aspects of self care.
   ☐I do not get dressed, wash with difficulty, and stay in bed

3. **Lifting** (mark only one)
   ☐I can lift heavy weights without extra pain
   ☐I can lift heavy weights but it gives extra pain
   ☐Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
   ☐Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
   ☐I can lift only very light weights
   ☐I cannot lift or carry anything at all

4. **Walking** (mark only one)
   ☐Pain does not prevent me from walking any distance
   ☐Pain prevents me walking more than 1 mile
   ☐Pain prevents me walking more than ½ mile
   ☐Pain prevents me walking more than ¼ mile
   ☐I can only walk using a stick or crutches
   ☐I am in bed most of the time and have to crawl to the toilet

5. **Sitting** (mark only one)
   - ☐I can sit in any chair as long as I like
   - ☐I can only sit in my favorite chair as long as I like
   - ☐Pain prevents me from sitting more than one hour
   - ☐Pain prevents me from sitting more than thirty minutes
   - ☐Pain prevents me from sitting more than ten minutes
   - ☐Pain prevents me from sitting at all

6. **Standing** (mark only one)
   - ☐I can stand as long as I want without extra pain
   - ☐I can stand as long as I want but it causes extra pain
   - ☐Pain prevents me from standing more than one hour
   - ☐Pain prevents me from standing more than thirty minutes
   - ☐Pain prevents me from standing more than ten minutes
   - ☐Pain prevents me from standing at all

7. Sleeping (mark only one)
   - ☐Pain does not prevent me from sleeping well
   - ☐I can sleep well only by using tablets
   - ☐Even when I take tablets I have less than six hours of sleep
   - ☐Even when I take tablets I have less than four hours of sleep
   - ☐Even when I take tablets I have less than two hours of sleep
   - ☐Pain prevents me from sleeping at all

8. Employment/Homemaking (mark only one)
   - ☐My normal homemaking/job activities do not cause pain
   - ☐My normal homemaking/job activities increase my pain, but I can perform all thatôs needed of me
   - ☐I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)
   - ☐Pain prevents me from anything but light duties
   - ☐Pain prevents me from doing even light duties
   - ☐Pain prevents me from performing any job or homemaking chores

9. Social Life (mark only one)
   - ☐My social life is normal and gives me no extra pain
   - ☐My social life is normal but increases the degree of pain
   - ☐Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
   - ☐Pain has restricted my social life and I do not go out as often
   - ☐Pain has restricted my social life to home
   - ☐I have no social life because of pain

10. Traveling (mark only one)
   - ☐I can travel anywhere without extra pain
   - ☐I can travel anywhere but it gives me extra pain
   - ☐Pain is bad but I manage journeys over two hours
   - ☐Pain restricts me to journeys less than one hour
   - ☐Pain restricts me to short journeys under thirty minutes
   - ☐Pain prevents me from traveling except to the doctor or hospital

Treatments:

Please list the physicians, chiropractors, and/or osteopaths you have seen within the **LAST YEAR** for your back/neck pain, along with the approximate dates.

Doctorôs Name	Type of Doctor	Approximate Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Treatment Used	Currently using?		**Effect of Treatment** Helped	No change	Increased symptoms
☐ Home exercise program	Yes	No	1	2	3
☐ Bed rest	Yes	No	1	2	3
☐ Hot packs/ice	Yes	No	1	2	3
☐ TENS unit for home use	Yes	No	1	2	3
☐ Back brace	Yes	No	1	2	3
☐ Physical therapy (see below)	Yes	No	1	2	3
☐ Massage	Yes	No	1	2	3
☐ Chiropractic treatment (see below)	Yes	No	1	2	3
☐ Osteopathic manipulation	Yes	No	1	2	3
☐ Acupuncture	Yes	No	1	2	3
☐ Epidural injections (see below)	Yes	No	1	2	3
☐ Facet injections	Yes	No	1	2	3
☐ Local (trigger point) injections	Yes	No	1	2	3
☐ Under care of pain specialists	Yes	No	1	2	3
☐ Other _____	Yes	No	1	2	3

Physical Therapy (PT/OT):

Have you been prescribed physical or occupational therapy? ☐Yes ☐No

Have you been evaluated and/or treated by a PT/OT specialist? ☐Yes ☐No

For approximately how long have you been undergoing therapy? (If possible, please state number of visits per week as well as the length of time) Visits per week _____ Length of time (weeks) _____

Briefly describe your experience with therapy (i.e. What do you do with the therapist? Do you feel better afterwards? If so, for how long?)_____

_____

_____

Chiropractic Manipulation:

Have you been evaluated and/or treated by a Chiropractor? ☐Yes ☐No

For approximately how long have you been undergoing therapy? (If possible, please state number of visits per week as well as the length of time) Visits per week _____ Length of time (weeks) _____

Briefly describe your experience with therapy (i.e. What do you do with the chiropractor? Do you feel better afterwards? If so, for how long?) _____

_____

_____

Epidural Steroid Injections:

Have you been treated with epidural steroid injections for this problem? ☐Yes ☐No

How many injections have you had? (Dates of injections if possible)_____

Do you feel better afterwards? If so how long_____

_____

_____

Patient Name:_____ Date of Birth: _____/_____/_____

Social / Environmental History

Education:

☐High school diploma/GED ☐College/Vocational ☐Did not complete High School/GED
What is your highest level of education or training? _____

Marital Status:

What is your marital status? ☐Married/Partner ☐Divorced/Separated ☐Single ☐Widowed
Have you had a stress or change in a significant relationship within the past 12 months? ☐Yes ☐No
If yes, please explain: _____
What are the ages of your children? _____

Habits:

1. Do you currently smoke or use tobacco? ☐Yes ☐No - If yes, at what age did you start? _____
   (Check all that apply) ☐cigarettes ☐cigars ☐ chew tobacco Age began: _____
2. Indicate the average amount smoked daily:
   ☐less than 1 pack a day ☐1 pack per day ☐1 to 2 packs per day ☐more than 2 packs per day
3. If youôve quit smoking, at what age? _____
4. How often do you have a drink containing alcohol?
   ☐never ☐monthly or less ☐2-4 times a month ☐2-3 a week ☐4 or more a week
5. How many drinks containing alcohol do you have on a typical day when you are drinking?
   ☐1 or 2 ☐3 or 4 ☐5 or 6 ☐7 to 9 ☐10 or more
6. Do you use any recreational drugs? ☐Yes ☐No (This information is confidential)
   If so, what kind? _____

Sleep:

Have you had any of these sleep problems <u>at least half the days of the past month</u>?

- Trouble falling asleep when you first go to bed ☐Yes ☐No
- Waking up during the night and not easily going back to sleep ☐Yes ☐No
- Waking up in the morning earlier than planned or desired ☐Yes ☐No
- Feeling unsatisfied or not rested by your nightôs sleep ☐Yes ☐No
- Feeling excessively sleepy during the day (does not include regular naps) ☐Yes ☐No

How many hours per night do you sleep currently, on average? _____
Did your sleep problems exist prior to your current pain problem? ☐Yes ☐No ☐No sleep problems now

Mood:

*These questions are about how you feel and how things have been with you **during the past four weeks**. For each question, please give one answer that comes closest to the way you have been feeling.*

Do you feel you might be depressed or overly anxious? ☐Yes ☐No
Circle the appropriate number to indicate the extent of the problem you are having with each of the following:

	NONE									SEVERE
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

Have you ever considered yourself a victim of physical, emotional or sexual abuse? ☐Yes ☐No
Are you receiving care from a mental health professional? ☐Yes ☐No If yes, please explain_____

Occupational History:

Employer: _____ Date of hire: _____ Usual occupation: _____

Briefly describe your job: _____

1. How physically demanding is your job?
   - ☐ Very heavy (frequently lifting over 50 pounds)
   - ☐ Heavy (frequently lifting 25-50 pounds)
   - ☐ Moderate (frequently lifting 10- 25 pounds)
   - ☐ Light (frequently lifting under 10 pounds)
   - ☐ Sedentary (essentially no lifting)

2. Work status at the **TIME OF ONSET** of this episode of back/neck pain:
   - ☐ Regular: full time
   - ☐ Regular: part time
   - ☐ Working modified job (e.g., light duty)
   - ☐ Not currently in workforce/homemaker/student
   - ☐ Unemployed, looking for work
   - ☐ Retired
   - ☐ On public assistance
   - ☐ Permanent disability (pension, SSDI)
   - ☐ Other_____

3. Work status **TODAY**
   - ☐ Regular: full time
   - ☐ Regular: part time
   - ☐ Working modified job (e.g., light duty)
   - ☐ Not currently in workforce/homemaker/student
   - ☐ Unemployed, looking for work
   - ☐ Regular: full time
   - ☐ Retired
   - ☐ On public assistance
   - ☐ Permanent disability (pension, SSDI)
   - ☐ Other_____
   - ☐ Retired

4. How satisfied are you with your job?
   ☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Worst job Iôve ever had ☐ N/A

5. If your back/neck got completely better during the next few weeks, do you think your employer would let you return to the job you had before this episode of back/neck pain?
   ☐ Yes ☐ Probably ☐ Doubt it ☐ Definitely not ☐ N/A

6. Is your employer able and willing to offer you job accommodations (e.g., light duty, part-time work, flexible schedule, special equipment) if needed to allow you to work? Yes No Donôt Know N/A

7. How certain are you that you will be working in 6 months? (circle one)

   0 1 2 3 4 5 6 7 8 9 10
   Not at all Certain Definitely

8. When do you expect to return to work?
   ☐ Next 2 weeks ☐ 2-6 weeks ☐ 6-12 weeks ☐ 3-6 months ☐ more than 6 months ☐ never ☐ N/A

9. Are you planning to apply for permanent disability such as Social Security Disability (SSDI) or other disability? (e.g., workerôs compensation) ☐ Yes ☐ No

10. Has your employer treated you fairly?
    ☐ Yes ☐ No ☐ N/A If no, please explain: _____

11. Has anyone in your family been on disability coverage? ☐ Yes ☐ No
    If yes, what is the relationship to you? _____

12. Is a lawyer helping you with a claim or lawsuit related to your current pain or other symptoms?
    ☐ Yes ☐ No If yes, explain briefly _____

Patient Name:_____ Date of Birth: _____/_____/_____

Family History:

Please indicate if history of diabetes, cancer, heart disease, seizures, neurological, or other ñfamilyò disease.

	Living?		Age or ages at death	Present health or cause of death
Father	❒ Yes ❒ No			
Mother	❒ Yes ❒ No			
Spouse	❒ Yes ❒ No			
Brothers	# Living			
	# Deceased			
Sisters	# Living			
	# Deceased			
Children	# Living			
	# Deceased			
Current Living Situation: ❒ Live Alone ❒ With Family ❒ With Friends ❒ Homeless ❒ Other				

Current Review of Systems

***Right Now* do you have any of the following problems?**		***If yes, please explain:***
Neurological (i.e. any changes in sight, smell, hearing and taste, seizures, faints, fits, funny turns, headache, pins and needles or numbness, poor balance, speech problems, sphincter disturbance, higher mental function	❒ Yes ❒ No	
Eye (i.e. visual changes, headache, eye pain, double vision, blind spots, floaters or "feeling like a curtain got pulled down")	❒ Yes ❒ No	
Constitutional (i.e unexplained weight loss, night sweats, fatigue/malaise/lethargy, sleeping pattern, appetite, fever, itch/rash, recent trauma, lumps/bumps/masses, unexplained falls)	❒ Yes ❒ No	
Ear/Nose/Throat (i.e. Runny nose, frequent nose bleeds (epistaxis), sinus pain, stuffy ears, ear pain, ringing in ears (tinnitus), gingival bleeding, toothache, sore throat, pain with swallowing (odynophagia))	❒ Yes ❒ No	
Cardiovascular (i.e. chest pain, irregular heart beat, tightness, trouble breathing lying flat, trouble breathing when exercising, swollen ankles)	❒ Yes ❒ No	
Respiratory (i.e. shortness of breath, wheezing, coughing blood, persistent cough)	❒ Yes ❒ No	
Gastrointestinal (i.e. nausea, heartburn, abdominal pain, diarrhea, change in bowel habits, excessive constipation, black or bloody stools)	❒ Yes ❒ No	
Genitourinary (i.e. pain, incontinence, incontinence, pain or blood with urine, hesitancy, dribbling, decreased force of stream, vaginal discharge or pain, Menses - frequency, regularity, heavy, pregnancy, menopause	❒ Yes ❒ No	
Endocrine (i.e. diabetes, thyroid disease, menstrual problems, heat or cold intolerance, eating or drinking all the time)	❒ Yes ❒ No	
Hematologic/Lymphatic (i.e anemia, red or purple skin discolorations, results from routine hemolytic diseases screening, prolonged or excessive bleeding after dental extraction / injury, use of anticoagulant and antiplatelet drugs (including aspirin), family history of hemophilia, history of a blood transfusion, refused for blood donation)	❒ Yes ❒ No	
Musculoskeletal (i.e morning stiffness, muscle tenderness, dry eyes or mouth, white fingers in cold, skin rashes, joint pain or swelling)	❒ Yes ❒ No	
Skin/Integumentary (i.e Itchiness, rashes, stretch marks, lesions, wounds, incisions , nodules, tumors, eczema, excessive dryness and/or discoloration)	❒ Yes ❒ No	

Allergic/Immunologic (i.e difficulty breathing or choking as a result of exposure to anything (and state what; e.g. "bee sting"). Swelling or pain at groin, axilla or neck, allergic response (rash/itch) to materials, foods, animals (e.g. cats); reaction to bee sting, unusual sneezing (in response to what), runny nose or itchy/teary eyes; food, medication or environmental allergy test results)	❒ Yes ❒ No	
Psychiatric (i.e depression, sleep patterns, anxiety, difficult concentrating, body image, work and school performance, paranoia , lack of energy, episodes of mania, episodic change in personality, expansive personality, sexual or financial 'binges')	❒ Yes ❒ No	
Do you take at least 1000 mg of calcium daily?	❒ Yes ❒ No	

When was your last physical exam? _____ **By Whom?** _____
If you have not had a physical within the last year and you have symptoms from the list, you MUST contact your primary doctor. Please contact your PCP for general medical issues.

Past Medical History

Have you previously been diagnosed with any of the following:

Medical Problems:		***If yes, please explain:***
Vascular		
Heart Attack or MI	❒ Yes ❒ No	
Heart Failure or CHF	❒ Yes ❒ No	
Stents to heart, legs, other	❒ Yes ❒ No	
Abnormal Rhythm (A-fib)	❒ Yes ❒ No	
Peripheral Vascular Disease	❒ Yes ❒ No	
Vascular Claudication	❒ Yes ❒ No	
High Cholesterol	❒ Yes ❒ No	
Stroke or TIA	❒ Yes ❒ No	
Hypertension/High Blood Pressure	❒ Yes ❒ No	
Coronary Artery Disease	❒ Yes ❒ No	
CABG or other Bypass Surgery	❒ Yes ❒ No	
Pulmonary		
Asthma	❒ Yes ❒ No	
COPD or emphysema	❒ Yes ❒ No	
Sleep Apnea	❒ Yes ❒ No	
Do you require an inhaler?	❒ Yes ❒ No	
Do you require oxygen?	❒ Yes ❒ No	
Gastrointestinal		
Acid Reflux or GERD	❒ Yes ❒ No	
Previous Abdominal Surgery	❒ Yes ❒ No	
Liver Disease	❒ Yes ❒ No	
Inflammatory Bowel (ie Crohns)	❒ Yes ❒ No	
Diabetes	❒ Yes ❒ No	
Age at onset _____		
Any Organ Damage?	❒ Yes ❒ No	
Neurologic		

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Fibromyalgia	❒ Yes ❒ No	
Reflex Sympatheic Dystrophy (RSD)	❒ Yes ❒ No	
. Complex Regional Pain Syndrome (CRPS) or Causalgia	❒ Yes ❒ No	
Neuropathy	❒ Yes ❒ No	
Alzheimers Dementia	❒ Yes ❒ No	
Other Neurologic problem (specify)	❒ Yes ❒ No	
Hematologic (Blood) disorders		
Anemia	❒ Yes ❒ No	
Bleeding Disorders	❒ Yes ❒ No	
Do you take Aspirin, Plavix, Warfarin, Coumadin or any other blood thinner?	❒ Yes ❒ No	
Other		
Cancer (specify)	❒ Yes ❒ No	
Gout	❒ Yes ❒ No	
Thyroid	❒ Yes ❒ No	
Osteoporosis	❒ Yes ❒ No	
Arthritis	❒ Yes ❒ No	
Chronic Infection	❒ Yes ❒ No	
Previous Surgical Wound Infection?	❒ Yes ❒ No	
ANY OTHER MEDICAL CONDITIONS?	❒ Yes ❒ No	
If yes, please list: _____		
Psychiatric Care		
❖ Depression	❒ Yes ❒ No	
❖ Anxiety	❒ Yes ❒ No	

If you have had surgery on your **Back and/or Neck** please fill in the following for each operation:

Date	**Type of Surgery and Surgeon**	**Pain After Surgery** Worse	Same	Better
_____	_____	____	____	____
_____	_____	____	____	____
_____	_____	____	____	____

Other Prior Surgeries (please list)	Approximate Date	Other Prior Surgeries (please list)	Approximate Date

Have you EVER had any problems with surgery or anesthesia? ☐No ☐Yes- Explain: _____

Diagnostic Tests:

Which of the following diagnostic tests have been done on your back/neck? Please indicate date for ñyesò answers.

Test Type	Approximate Date	Test Location
Regular x-rays		
MRI Scan		
CT Scan		
Myelogram		
Other*		

*Includes Bone Scan, EMG, Discogram, Bone Denstiy testing

Medication Record

In order to prevent mistakes with your medications, please transfer the information from the labels on your prescription bottles to this sheet. Accurate information is required for your safety.

Name of Medication (e.g.: Plavix)	Dosage/Strength: (e.g.: 250mg)	Schedule: (e.g.: 1 tablet 2x per day)	Reason for taking this medication:

ALLERGIES:

Medication Allergies (List all)	Reaction