Mid-State Neurosurgery, P.C
Back & Neck Pain Center

Patient Name: _____ **Date of Birth:** _____

HISTORY OF PRESENT ILLNESS

What is the reason for today's visit? _____

When did the problem begin? _____

How did the problem begin? _____

Is your injury due to an accident?

__ Work Accident __ Car Accident __ Other

Date of Accident: _____

Please describe the details of the accident: _____

_____

_____

Where are your symptoms?

__ Head __ Right Arm __ Mid-Back __ Left Leg __ Other: _____
__ Neck __ Left Arm __ Low Back __ Right Leg

Do your symptoms travel to any of these locations?

__ Shoulder __ Forearm __ Buttocks __ Calf __ Foot
__ Upper Arm __ Fingers __ Thigh __ Ankle __ Toes

How often do your symptoms occur?

__ Intermittent
__ Constant

How do your symptoms feel?

__ Sharp Pain __ Dull Pain __ Numb __ Weakness
__ Shooting Pain __ Throbbing Pain __ Tingling Sensation __ Other: _____
__ Stabbing Pain __ Ache __ Pins & Needles

Do you have any of these symptoms?

☐ None

__ Bowel Incontinence __ Difficulty with Balance __ Coordination Problems
__ Bladder Incontinence __ Difficulty Walking __ Headache

How much do your symptoms bother you?

☐ 0 (No Pain) ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Worst Pain Ever)

What makes your symptoms better?

__ Lying Down __ Standing __ Heat __ Bending Forward
__ Sitting __ Walking __ Cold __ No Position of Comfortable
__ Other: _____

What makes your symptoms worse?

__ Lying Down __ Bending Forward __ Sneezing __ Movement of Neck
__ Sitting __ Climbing Stairs __ Coughing __ Movement of Arm
__ Standing __ Sitting to Standing __ Driving __ Movement of Leg
__ Walking __ Lifting Objects __ Other: _____

Patient Name: _____ **DOB:** _____

HISTORY OF PRESENT ILLNESS

What tests have been performed?

☐ None
__ MRI
__ CT
__ EMG/NCV
__ X-rays

What treatment have you tried?

☐ None

	No Benefit	Improved	Temporary Relief
Oral Steroids	☐	☐	☐
Pain Medication	☐	☐	☐
Anti-Inflammatory Medicine	☐	☐	☐
Muscle Relaxer	☐	☐	☐
Physical Therapy	☐	☐	☐
Traction Unit	☐	☐	☐
Chiropractor	☐	☐	☐
Wrist Splints	☐	☐	☐
Epidural Steroid Injections	☐	☐	☐
Facet Injections	☐	☐	☐
Trigger Point Injections	☐	☐	☐
Radiofrequency Ablation	☐	☐	☐
TENS Unit	☐	☐	☐
Other: _____	☐	☐	☐

REVIEW OF SYSTEMS

Place a check next to the symptom below if you have had **any** of these symptoms in the **past 3 months.**

General
__ Chills
__ Fatigue
__ Fever
__ Weight Gain
__ Weight Loss

Integumentary
__ Dry Skin
__ Easy Bruising
__ Hair Loss
__ Hives
__ Rash

Eyes, Ears, Nose, and Throat
__ Blurry Vision
__ Double Vision
__ Visual Loss
__ Wear Eyeglasses or Contact Lenses
__ Dizziness
__ Bloody Nose
__ Hearing Loss
__ Hoarseness
__ Sinus Problems
__ Ringing in Ears
__ Trouble Swallowing

Respiratory
__ Cough
__ Shortness of Breath
__ Wheezing

Cardiovascular
__ Chest Pain
__ Calf Pain When You Walk
__ Heart Palpitations
__ Leg Swelling
__ Fainting

Gastrointestinal
__ Abdominal Pain
__ Bowel Incontinence
__ Constipation
__ Diarrhea
__ Nausea
__ Vomiting

Genitourinary
__ Bladder Incontinence
__ Painful Urination
__ Frequent Urination
__ Trouble Beginning Urinary Stream
__ Urinary Urgency

Musculoskeletal
__ Joint Pain
__ Joint Swelling
__ Low Back Pain
__ Muscle Weakness
__ Neck Pain

Neurological
__ Arm Weakness
__ Headache
__ Leg Weakness
__ Loss of Consciousness
__ Memory Loss
__ Poor Balance
__ Seizure

Psychiatric
__ Anxious
__ Depressed
__ Insomnia
__ Trouble Concentrating

Endocrine
__ Intolerance to Cold
__ Intolerance to Heat
__ Excessive Thirst

Patient Name: _____ **DOB:** _____

MEDICATIONS Please list **all** medications and dosages you are currently taking, including over-the-counter medications.

☐ None

1. _____ 11. _____
2. _____ 12. _____
3. _____ 13. _____
4. _____ 14. _____
5. _____ 15. _____
6. _____ 16. _____
7. _____ 17. _____
8. _____ 18. _____
9. _____ 19. _____
10. _____ 20. _____

Do you take any of the following medications? ☐ None

__ Naprosyn
__ Aleve
__ Naproxen
__ Advil
__ Motrin
__ Ibuprofen
__ Coumadin
__ Warfarin
__ Plavix
__ Aspirin
__ BC Powder
__ Goody Powder
__ Vitamin E
__ Glucosamine

ALLERGIES Please list any allergies and adverse reactions you have to medications or food.

☐ None

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Are you allergic to any of the following? ☐ None

__ Latex
__ Adhesive Tape
__ Gadolinium (MRI Contrast Dye)
__ Iodine (CT Contrast Dye)

PHARMACY INFORMATION Please provide the name, street address, and phone number of your pharmacy.

Name: _____ Phone: _____

Street Address: _____

PAIN MANAGEMENT

Are you currently in Pain Management or receiving pain medicine from another physician? Yes No

If yes, please list the name and address of this physician/medical practice:

Name: _____ Phone: _____

Address: _____ Fax: _____

Patient Name: _____ **DOB:** _____

PAST MEDICAL HISTORY Place a check next to the disease below if you have ever been diagnosed with it in the past.

Integuementary
__ Breast Cancer
__ Melanoma
__ Shingles (Herpes Zoster)

Eyes, Ears, Nose, and Throat
__ Cataracts
__ Glaucoma
__ Legally Blind
__ Meniere's Disease
__ Seasonal Allergies

Respiratory
__ Asthma
__ COPD
__ Emphysema
__ Lung Cancer
__ Pulmonary Embolism (PE)
__ Sleep Apnea
__ Tuberculosis

Cardiovascular
__ Abdominal Aortic Aneurysm
__ AICD (Defibrillator)
__ Atrial Fibrillation
__ Blood Clot (DVT)
__ Congestive Heart Failure
__ Heart Attack
__ High Blood Pressure
__ High Cholesterol
__ Pacemaker
__ Peripheral Vascular Disease (PVD)
__ Stroke

Gastrointestinal
__ Crohn's Disease
__ Cirrhosis
__ Diverticulosis
__ Gallbladder Disease
__ Gastric Ulcer
__ Hepatitis B
__ Hepatitis C
__ Irritable Bowel Syndrome (IBS)
__ Liver Cancer
__ Pancreatitis
__ Ulcerative Colitis

Genitourinary
__ Bladder Cancer
__ Enlarged Prostate (BPH)
__ Kidney Failure (on dialysis)
__ Kidney Stones
__ Prostate Cancer

Neurological
__ Brain Tumor
__ Concussion
__ Dementia
__ Migraine Headache
__ Multiple Sclerosis (MS)
__ Parkinson's Disease
__ Seizure Disorder

Endocrine
__ Diabetes
__ High Thyroid
__ Low Thyroid

Musculoskeletal
__ Compression Fracture
__ Fibromyalgia
__ Gout
__ Lupus (SLE)
__ Osteoporosis
__ Polio
__ Psoriatic Arthritis
__ Rheumatoid Arthritis
__ Scoliosis

Psychiatric
__ Anxiety Disorder
__ Bipolar Disorder
__ Depression

Other
__ AIDS
__ Endometriosis
__ HIV
__ Leukemia
__ Lyme Disease
__ Substance Abuse

PAST SURGICAL HISTORY List any **back, neck, or brain surgery** you have had with the approximate year. Place a check next to any other surgeries/procedures you have had. ☐ **None**

Neck Surgery:

Back Surgery:

Brain Surgery:

__ Carpal Tunnel
__ Ulnar Nerve
__ Spinal Cord Stimulator
__ Intrathecal Pain Pump

__ Abdominal Aortic Aneurysm
__ Appendectomy
__ Ankle Surgery
__ Bladder Stimulator
__ Cardiac Bypass
__ Cardiac Stent
__ Carotid Artery Plaque Removal
__ Carotid Artery Stent
__ Cataract
__ Colonoscopy

__ Gallbladder Removed
__ Gastric Bypass
__ Heart Valve Replacement
__ Hernia Repair
__ Hip Replacement
__ Hysterectomy
__ Knee Replacement
__ Mastectomy
__ Pacemaker
__ Prostate Surgery
__ Shoulder Surgery
__ Thyroid Removed
__ Tonsillectomy
__ Other:
_____

Have you ever had a problem with anesthesia? Yes No
If yes, please explain: _____

Have you ever had a blood transfusion? Yes No
If yes, why? _____

Patient Name: _____ **DOB:** _____

SOCIAL HISTORY

Job Title: _____

Employer Name: _____

Current Work Status:
__ Full Time
__ Part Time
__ Unemployed
__ Self Employed
__ Retired
__ Disabled

Do you drink alcohol?
__ Yes, Every day
__ Yes, Some days
__ Yes, Only Socially
__ No, I quit
__ No, I have never drank alcohol

Do you smoke?
__ Yes, Every day
__ Yes, Some days
__ No, I quit
__ No, I have never smoked

Marital Status:
__ Married
__ Single
__ Divorced
__ Widowed
__ Domestic Partner

Do you have children? Yes No

If yes, how many sons? _____

If yes, how many daughters? _____

FAMILY HISTORY

Please check if your mother, father, or siblings has or had any of the following diseases.

☐ Patient is adopted

	Mother	Father	Sister(s)	Brother(s)
Asthma	☐	☐	☐	☐
Anxiety Disorder	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐
Brain Tumor	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
High Thyroid	☐	☐	☐	☐
Low Thyroid	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Other Cancer _____	☐	☐	☐	☐