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:_____ AGE:_____ DOB:_____ RIGHT HANDED ___ LEFT HANDED ____ AMBIDEXTROUS____

ALLERGIES:_____ OCCUPATION: _____ Today's Date: _____

HOME ADDRESS _____

_____

CITY _____ STATE _____

ZIP _____PHONE _____

Home /Cell/ Best contact #:_____

EMAIL :_____

Chief Complaint (What are you being seen for?)

example: neck pain, back pain, right arm pain, left leg pain etc.

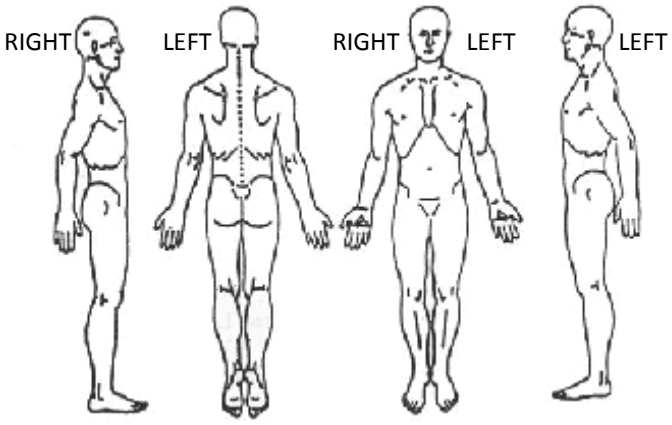
List:_____

CIRCLE ALL THAT APPLY: **Weakness, Numbness, Tingling, Burning, Stabbing, Electricity, Dull Ache, Gnawing, Pins and Needles.**

Date of onset of symptoms:_____

How long symptoms have been: _____

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



How bad is your Pain? (Circle the number)

0 1 2 3 4 5 6 7 8 9 10

Circle all treatments Tried: Nonsteroidal anti-inflammatory drugs (NSAIDS), Lyrica, Neurontin, Ibuprofen, Aleve, Naproxen, Motrin, Celebrex, Mobic, Physical Therapy, Chiropractor Care, Pain medications, Muscle Relaxers, Brace, Home Exercises, Acupuncture, Cervical Spine Injections, Lumbar Spine Injection, Epidural Injection, Thoracic Spine Injection, Facet Injections, Nerve Ablation, Spine Surgery,
List other treatments tried:_____

_____

ORTHOPAEDIC INJURY

WAS AN AUTOMOBILE INVOLVED? ____YES ____NO
WAS INJURY WORK RELATED? ____YES ____NO
LITIGATION PENDING? ____YES ____NO
Describe Injury or condition :_____

_____

_____

_____

_____

_____

What aggravates the pain? __Walking __Standing __Sitting __Lying Down __Stooping/Bending __Activity in General __Nothing in Particular __Other/comments:_____

_____

_____

What makes the pain better? __Sitting __Lying Down __Walking __Standing __Heat or Cold Compress __Nothing in particular __Other/comments:_____

_____

_____

Please **CIRCLE** if you now have or have had recently any of the following: N**eurological**: Frequent headaches, paralysis on one side, Numbness on one side, Slurred speech, Double vision, Loss of Consciousness, Incoordination; **GENERAL: Fever, Weight loss, Excessive tiredness; EYE:** Blindness, cataract, Glaucoma, Sudden loss of vision in one eye; **EARS:** Hearing loss, recurrent ear infections, Vertigo; **THROAT:** Swallowing difficulty, Jaw pain on chewing; **CARDIAC:** chest pain, Heart attack, Irregular heart beat; **RESPIRATORY:** Shortness of breath, Persistent Cough, Blood in sputum; **GASTROINTESTINAL:** Diarrhea, Stomach pain, Constipation, Vomiting, Blood in stools, Tarry stools; **HEMATOLOGIC:** Unusual bleeding, Easy bruising; **GENITOURINARY:** Difficulty Urinating, Incontinence, Recurrent bladder infections, Changes in bowel or bladder function; **MUSCULOSKELETAL:** Painful joints, Cramps, Joint stiffness; **SKIN: Rashes, ALLERGIC:** Red eyes, Hives, Nasal congestion; **ENDOCRINE:** Excessive thirst, Excessive urination, Hot flashes; **OTHER:** Hallucinations, Sleep disturbances, Diminished interest or pleasure from most activities, Feeling of Guilt/Worthlessness, Loss of Energy, Difficulty concentrating, Appetite changes, Depressed mood, Agitation or sluggishness, suicidal thoughts, Homicidal thoughts, Panic attacks.

SINCE THE PAIN/CONDITION BEGAN IT:
____Has Improved ___Comes & Goes
____Has worsened ___ Stayed the same

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

Any difficulty walking relating to presenting symptoms? Y/N
Do you use any assistive device(s) for ambulation (e.g. Wheelchair, walker, cane, crutches, scooter, etc.)?
If yes, which assistive device do you use? _____

CURRENT MEDICATIONS:

Medication Dosage # of times taken a day

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you take Aspirin or Blood Thinners: _Yes _No
(List Item above)

SURGICAL HISTORY

List all prior spine surgeries:

Date	Place	Surgeon	Procedure

List all other surgeries:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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 _____

Name Of Pharmacy:_____
Phone # : _____ City:_____
Fax #: _____

FAMILY HISTORY

Do you have a family history of the following? (Circle all that apply): Heart Disease, High Blood Pressure, Stroke, Cancer, Diabetes, Osteoarthritis, Rheumatoid Arthritis, Scoliosis, Back Problems, Neck Problems, Other:_____

SOCIAL HISTORY

Smoke: Yes or No → **Packs Per Day**___ For___ years ☐ No, Quit in_____ ☐ Never A Smoker:_____
Alcohol: Yes or 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

__ Hospital
__Another Patient
__Self-Referral
__Other Advertisement
__ Physician
__ TV
__Website
__ Other:_____

WORK STATUS

Employed __Yes __No Employer:_____
a)If no, out of work since what date: _____
b) Reason for unemployment:_____
_____

Please use back page for additional writing space.