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 #:_____

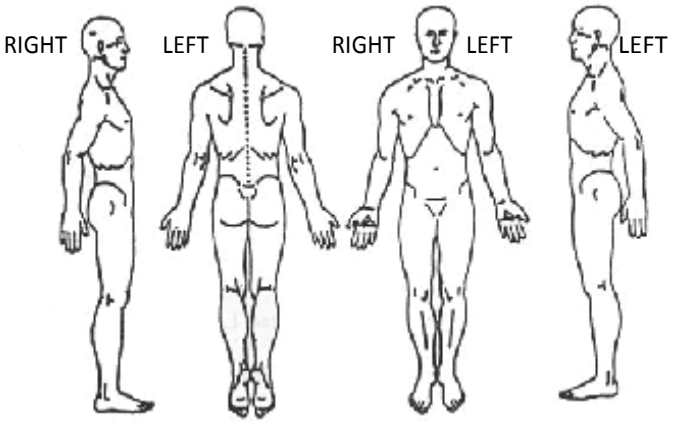
EMAIL :_____

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	GERD	Yes	No	Liver Disease
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			

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): 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 TV
__Another Patient __Website
__Self-Referral Other:_____
__Other Advertisement
Phvsician

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.