St. Joseph Health Medical Group

Today's Date: _____ **NEUROSURGERY**

Name: (Last) _____ (First) _____ (MI) _____

Age: _____ Birth Date: _____ ☐ Female ☐ Male Dominant hand: ☐ Right ☐ Left

Pharmacy- Name: _____ Phone: _____ Location: _____

What are you being seen for today? _____ Location of pain (indicate left or right) _____

How long have you had these symptoms? _____ What helps? _____

What makes it worse? _____ What treatments have you had? _____

Is this Workers Compensation? ☐ Yes ☐ No Claim#: _____ DOI: _____

Do you have an attorney? ☐ Yes ☐ No If yes, then who? _____

Please mark the severity of your pain on the following line:

On your **worst days** with a **W** On your **average days** with an **A** On your **best days** with a **B**

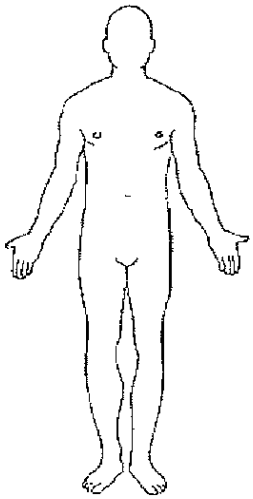
No Pain 0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10 **Most severe pain**

Pain Diagram

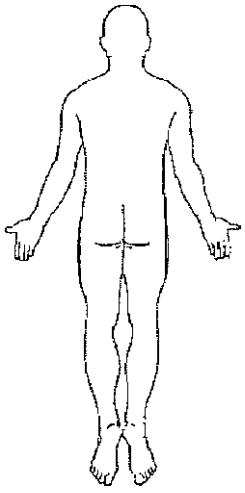
Mark the areas on your body where you feel the described sensations. Please mark all affected areas. Use the appropriate symbols:

Numbness ---- **Pins/Needles 000** **Burning XXX** **Stabbing ///** **Aching +++**

Front right



Left



Back right

Review of Systems

Do you currently have or have had in the past 8-12 weeks?

General	Yes	No
Recent fever/chills	☐	☐
Significant weight loss	☐	☐
Skin		
Bruising	☐	☐
Rash	☐	☐
Eyes/Ears/Nose/Throat/Mouth		
Mouth sores	☐	☐
Change/blurring of vision	☐	☐
Double vision	☐	☐
Ear infections	☐	☐
Hearing loss	☐	☐
Ringing in the ears	☐	☐
Vertigo	☐	☐
Nasal congestion	☐	☐
Recent sore throat	☐	☐
Respiratory		
Cough (recent or chronic)	☐	☐
Shortness of breath	☐	☐

Cardiovascular	Yes	No
Calf pain w/ walking	☐	☐
Chest pain	☐	☐
Leg swelling	☐	☐
Irregular heartbeat	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Blood in stools	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Genitourinary	☐	☐
Painful urination	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Musculoskeletal		
Joint pain or swelling	☐	☐
Muscle pain	☐	☐

Neurological	Yes	No
Confusion	☐	☐
Memory loss	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Headaches	☐	☐
Balance Problems	☐	☐
Numbness/tingling	☐	☐
Seizures	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Endocrine		
Excessive thirst	☐	☐
Cold/heat intolerance	☐	☐
Low blood sugar	☐	☐
Hormone replacement	☐	☐
Steroid use	☐	☐
Hematologic		
Excessive bleeding	☐	☐

Past Medical History

Check the medical problems you currently have or have had in the past

- ☐ Cancer, if so, what type? _____
- ☐ Congestive heart failure
- ☐ Heart disease, Cardiologist? _____
- ☐ Hypertension (high blood pressure)
- ☐ Heart attack
- ☐ Ulcers/GERD
- ☐ History of blood transfusions
- ☐ Rheumatoid arthritis
- ☐ Seizures/epilepsy
- ☐ COPD

Past medical History Continued…

- ☐ Heart Murmur
- ☐ Diabetes: ☐ Insulin ☐ Oral meds ☐ Diet controlled
- ☐ Hypothyroidism
- ☐ Depression/anxiety
- ☐ Blood clots (DVT/Pulmonary embolus)
- ☐ Kidney disease
- ☐ Hepatitis: ☐ A ☐ B ☐ C
- ☐ Asthma, if yes, last hospitalization: _____
- ☐ Sleep apnea, if yes, do you use a CPAP? ☐ Yes ☐ No
- ☐ Stroke
- ☐ MRSA (Methicillin resistant staph aureus)
- ☐ Other: _____

_____

Allergies

Please list all allergies, including medications, iodine and contrast.

☐ None known OR ☐ Yes, if so, please list them:

_____

_____

Family History

Please list family history. If yes, list relative, if they are living and the age at death if deceased.

Problem list	Yes	No	Relative	Living? Yes	Living? No	Age of death
Blood clotting disorders?	☐	☐	_____	☐	☐	_____
Cancer? What type? _____	☐	☐	_____	☐	☐	_____
Diabetes?	☐	☐	_____	☐	☐	_____
Heart disease/heart attack?	☐	☐	_____	☐	☐	_____
Hypertension (high blood pressure)	☐	☐	_____	☐	☐	_____
Stroke?	☐	☐	_____	☐	☐	_____
Other? _____				☐	☐	_____

Social History

	Yes	No	
History of substance abuse?	☐	☐	If yes, describe: _____
Do you drink alcohol?	☐	☐	If yes, ☐ Occasional ☐ Moderate ☐ Heavy
Smoke currently?	☐	☐	If yes, _____ packs/day for _____ years

Social History Continued…

	Yes	No	
Quit smoking?	☐	☐	If yes, how long ago did you quit? _____
Are you married?	☐	☐	If yes, what's your spouse's name? _____
Employed?	☐	☐	☐ Full time ☐ Part time ☐ Disabled ☐ Retired
			Occupation? _____
Do you have children?	☐	☐	If yes, number of children: _____
Student?	☐	☐	*Pediatric patients (Ages 0-16) Grade level? _____
			Name of school/daycare attending? _____

*Pediatric patients (0-16): Are immunizations current? ☐ Yes ☐ No

Medications

List ALL medications, including over the counter products, minerals, vitamins, herbal and dietary supplements. For pain medications, please include the date started and the provider that does the refills.

Drug name	Dose/how often
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History

Please list all surgeries you have had, including the date. Circle Right or Left, if applicable.

Prior joint surgeries		Yes	No	Date	Other surgeries	Yes	No	Date
Hip	☐ R ☐ L	☐	☐	_____	Heart surgery/heart stents	☐	☐	_____
Knee	☐ R ☐ L	☐	☐	_____	Appendectomy	☐	☐	_____
Shoulder	☐ R ☐ L	☐	☐	_____	Tonsillectomy	☐	☐	_____
Neck		☐	☐	_____	Gallbladder	☐	☐	_____
Back		☐	☐	_____	Hysterectomy	☐	☐	_____

Other surgeries not listed, type and date:

_____

_____

Diagnostic Studies

Which of the following diagnostic tests have been done on your head/neck/back? Please indicate the date below.

	Yes	No	Date	*(M.D. use only)*
Regular Spine X-ray	☐	☐	_____	_____
CT Scan	☐	☐	_____	_____
MRI Scan	☐	☐	_____	_____
Myelogram	☐	☐	_____	_____
Discogram	☐	☐	_____	_____
Bone Scan	☐	☐	_____	_____
EMG	☐	☐	_____	_____
Nerve Blocks	☐	☐	_____	_____
Facet Blocks	☐	☐	_____	_____

Conservative Care

What types of conservative care have you tried? (Physical Therapy, Chiropractic, Massage Therapy)

What type?	**Where?**	**How long? (date range; # of visits)**	**Did you get any relief?**
_____	_____	_____	_____
_____	_____	_____	_____

Are you claustrophobic? ☐ Yes ☐ No Do you have any metal in your body? ☐ Yes ☐ No

Patient/Guardian's Signature: _____ Date: _____